

CHILDREN/YOUTH
PERFORMANCE
OUTCOME
MEASUREMENT SYSTEM

CLINICAL TRAINING
MANUAL

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SECTION 1 - WHY PERFORMANCE OUTCOMES?

National Trends

In response to initiatives and discussions at national, state and local levels, there is an increasing interest in developing and implementing measures of system and client-level outcomes. National organizations, state mental health agencies, and county mental health authorities are currently in the process of developing and implementing mental health performance outcome measurement systems to ensure accountability for the expenditure of public behavioral healthcare dollars and for ensuring high quality and effective care to mental health consumers. As indicated in the following excerpts, performance outcome measurements are becoming an increasingly important tool in making service-related decisions in the public mental health system.

“The demand for accountability has been pressing against the doors of mental healthcare organizations and independent practitioners for over a decade. The fast emerging age of managed care and universal healthcare has intensified the demand for accountability. It is now very real and the doors have been opened. State legislatures, the U.S. Congress, private payers, and consumers now routinely ask questions about the necessity and quality of mental health services (Goodman, Brown, & Deitz, 1992; Mintz & Kiesler, 1982). As a result, the mental healthcare profession has entered an era of scrutiny never before experienced. To the practitioner who states that clinical needs and outcomes are too subjective to measure and quantify, payers are posed to respond in this manner: ‘Then they also may well be too subjective to pay for (Brown, 1991).’”¹

“With pressures all around for accountability in healthcare services, implementing strategies for measuring and reporting outcomes has become a way of life for providers. And in the psychiatric specialty field, proving need and value generally has been far more difficult than in the more physical areas. However, that has begun to change, as there are greater data gathering and sorting capabilities now than ever before. Sophisticated outcomes measurement and research in psychiatric care is gearing up to change the relationship with its payers.”²

Efforts toward performance measurement on the national level include, among others, the Mental Health Statistics Improvement Program (MHSIP), Performance Measures for Managed Behavioral Healthcare Programs (PERMS), and Candidate Indicators for County Performance Outcomes. Table 1-1 summarizes the proposed domains and measures for each of these national programs currently under development.

¹ Green, M. (1996) In Quest of Outcomes: the Larimer Project. Community Mental Health Journal 32(1), 11-21.

² Smith, J. (1993) Measuring an Inexact Science. Health Systems Review, 6-10.

TABLE 1-1: National Performance Outcome Systems in Development

National Program	Domains	Measures
MHSIP is a collaborative and cooperative venture between the Federal Government and the States to work towards achieving program, management, and performance monitoring improvement through the use of data. MHSIP provides guidance and technical assistance regarding mental health information systems, promotes uniformity through standards, and facilitates meaningful comparisons of costs, performance and services.	The MHSIP Report Card, a consumer-centered managed care report card, covers the general domains of access, quality and appropriateness, promotion/prevention and outcomes.	The MHSIP Report Card's proposed measures include speed and access to services, affordability, parity of coverage, consumer access to information, absence of cultural barrier, consumer health, quality of life, reduction in psychological stress, and consumer productivity and independence.
The American Managed Behavioral Healthcare Association, representing private managed behavioral healthcare providers on a national level, has field-tested PERMS 1.0 utilizing data collected from medical records, administrative data and client surveys.	PERMS organizes performance measures into access, consumer satisfaction and quality of care domains.	PERMS includes measures of service utilization, cost, penetration rates, call abandonment rates, and consumer satisfaction with access to clinical care, efficiency, and effectiveness.
Candidate Indicators for County Performance Outcomes are being developed by the Evaluation Center @ HSRI under a contract with the National Association of County Behavioral Healthcare Directors (NACBHD).	The NACBHD's proposed system includes access, consumer satisfaction, consumer outcomes, intersystem outcomes, and utilization domains.	Individual indications and measures of service include: level of staff cultural competence; location; speed, ease and timeliness; consumer satisfaction with comprehensiveness; integration of services with social supports; symptom management and level of wellness; level of independence; self-reliance and self esteem; level of consumer involvement in work, school, social and family relationships, contacts with other community providers; use of hospital care; and cost of services.

At the state level, performance measures are being developed in both states that have, as well as those that have not, introduced managed care reforms. Serious efforts have been underway for a number of years to develop performance and client measures to facilitate monitoring of contracts and to ensure continuous quality improvement. Approximately half of the states in the U.S. have developed, or are in the process of developing, report cards or performance outcome measurement systems.

Realignment Legislation

For many years, mental health funding was on a fiscal roller coaster, subject to the vagaries of the state budget. In 1991, Realignment legislation (Chapter 89, Statutes of 1991, also known as the Bronzan-McCorquodale Act) created a more stable funding source by earmarking a certain percentage of sales tax and the vehicle license fees for mental health funding.

Realignment legislation also specifies the maintenance and oversight of a public mental health service system for a target population of persons who are seriously mentally ill which is “client-centered, culturally competent, and fully accountable”. The legislation requires the development of a uniform, statewide client-based information system that includes performance outcome measures.

Realignment legislation requires that all counties report data on performance outcome measures to the State Department of Mental Health (DMH) which, in turn, is to make that data available to the California Legislature, local mental health boards and commissions, and the California Mental Health Planning Council (CMHPC).

Collaborative Process

The California Mental Health Directors Association (CMHDA), the California Mental Health Planning Council (CMHPC), and the Department of Mental Health (DMH) have collaborated on every step of the process for developing California’s mental health performance outcome system. Figure 1-1 provides a graphical representation of how the CMHDA, CMHPC, and DMH participate together in the planning process.

The central feature of the process is the Performance Outcome Advisory Group (POAG). The POAG is comprised of members drawn from the CMHDA, CMHPC, DMH, direct consumers, family members, and representatives of advocacy groups. The POAG, which is a policy level work group, reviews recommendations from the Performance Outcome Technical Work Group (POTWG) and makes recommendations to DMH for final decision. The POTWG is composed of members of the POAG as well as other individuals with specific clinical, policy, fiscal or data management expertise. The work group is co-chaired by the DMH, CMHDA, and CMHPC. All counties are welcome to attend work group meetings.

Together, these groups attempt to represent a balanced voice from all of the major constituencies. Their recommendations are presented to the DMH which, upon considering the issue from the State perspective, makes informed policy decisions.

Development of Children/Youth Performance Outcome Measurement System

The first attempt at collecting performance outcome data was based on a custom designed survey, the Adult Performance Outcome Survey (APOS), developed by DMH in conjunction with county and consumer representatives. This custom survey was designed to be administered to a sample of severely mentally ill (SMI) adult clients at a beginning time, 6 months later, and then again one year later. Several issues that emerged during this study include the difficulties of maintaining a representative sample and the lack of comparability of the data. Maintaining a representative sample became increasingly difficult as clients would drop out of service, move out of the area, or disappear for other reasons. In order to keep the sample representative, county staff had to spend time looking for these individuals which was

time consuming and not particularly cost

FIGURE 1-1

effective. Additionally, since the custom designed survey was only administered to a sample population, clinicians administering the survey found it to be more of an additional paperwork burden rather than the collection of useful data that they could use for treatment planning. And since the survey was custom designed and not a standardized instrument, the data was not comparable with other states or entities which is becoming increasingly important in an era where there is a national focus on performance measures.

Based upon the results from the APOS, the CMHDA, CMHPC, and DMH established several criteria for the Children/Youth Performance Outcome System which include:

- the data should be useful to clinicians for treatment planning;
- the data should be useful to counties for quality management purposes;
- the data must meet the requirements of the state for performance outcome data;
- and the data should be comparable with data from other states/entities.

Abram Rosenblatt, Ph.D., from the University of California at San Francisco and the contract evaluator for children's System of Care (SOC) counties was asked to provide his recommendation of what he thought would be a good way to both provide valid outcome data while giving clinicians useful information for use in their treatment planning and service provision. Dr. Rosenblatt, based on his extensive experience with children's systems of care, and in consultation with Norm Wyman of Santa Cruz County Mental Health and Don Kingdon who at that time worked for Ventura County Mental Health, recommended that the State adopt a series of seven assessment instruments. Some of these instruments are intended to be completed by the client, others by the parent or primary caregiver, and one by the clinician. Of the seven instruments, five are considered to be "core" or required, while two are optional but recommended. Refer to page 2-1 for a list of the children's performance outcome instruments including a description of what each instrument is intended to measure and who each is to be completed by.

The CMHDA reviewed the proposal that Dr. Rosenblatt developed. After a consideration of its strengths and weaknesses, the CMHDA recommended to the DMH that the model be adopted as the method for collecting and reporting performance outcome data. The CMHPC agreed to accept the data generated by the recommended model and with the concurrence of all three constituency groups, the model was accepted as the Children and Youth Performance Outcome System.

Usefulness to Clinicians

The set of instrument profiles and other data generated by the instruments is intended to provide clinicians with a multi-axial or multi-source method of collecting client-relevant data. This information may be used by the clinician for identify specific target areas that are most affecting the child's life and to select appropriate intervention techniques. Additionally, the clinician can evaluate the outcomes of the services he or she provides either to the same client over time or to

specific sub-populations of the clients he or she serves. Typically, the data may be used by the clinician to both supplement and cross validate his or her own clinical judgments. Finally, when appropriately used, the data can be a valuable tool to help parents and children to better understand the family's dynamics and the interpersonal or perceptual problems that may be exacerbating the child's presenting issues.

Frequently Asked Questions

- Why is it important that counties and the State measure mental health performance outcomes?

There are several reasons why measuring and reporting performance outcomes is important. The first reason for collecting outcome data is to ensure that public mental health programs are accountable for the expenditure of public funds. This is a predominant feature of Realignment, the legislation that mandated performance outcomes. Secondly, the emergence of managed care is making it increasingly important that public mental health programs be able to demonstrate that their programs are cost effective, while ensuring that client access to high quality and effective services is maintained. The federal government is also requiring states to produce outcome information to justify continuation of federal funds. Monitoring performance via outcomes as opposed to process is the approach adopted nationally by both the public and private health care sectors.

- How was the model of using this particular battery of children's instruments (i.e., CBCL, YSR, CAFAS, ROLES, CSQ-8) selected? Why is the State requiring counties to do this?

The current model of using a battery of widely recognized assessment instruments was developed by Abram Rosenblatt of the University of California, San Francisco Child Services Research Group, and contract evaluator for the Systems of Care counties in association with Don Kingdon of Ventura County and Norm Wyman of Santa Cruz county. They submitted a recommendation, which was adopted by the California Mental Health Directors Association, that a model similar to that used in Systems of Care counties be used statewide for collecting data related to performance outcomes. They suggested using the Child Behavior Check List (CBCL), the Youth Self Report (YSR), the Child and Adolescent Functional Assessment Scale (CAFAS), the Restrictiveness of Living Environments Scale (ROLES), and the Client Satisfaction Questionnaire (CSQ-8). In addition, two optional instruments that could be used in addition to the first five were suggested. These are the Youth Satisfaction Questionnaire (YSQ) and the Family Empowerment Scale (FES). The California Mental Health Planning Council agreed that the proposal would meet its oversight responsibilities, and the Department of Mental Health reviewed and accepted the proposal. Therefore, in a process that included the Planning Council, county mental health directors, and the State Department of Mental Health, the model was adopted.

- Is it possible to change the current methodology for the Children/Youth Performance Outcome System.?

Not at this time. The California Mental Health Planning Council (CMHPC) and the Department of Mental Health (DMH) must proceed with this system to come into compliance with legislation and thus have committed to using this system for a two year period. However, the CMHPC and DMH are committed to re-evaluating the existing system over this two year time period and will be examining potentially more cost effective and efficient instruments and methodologies.

SECTION 2 - OVERVIEW OF THE CHILDREN/YOUTH PERFORMANCE OUTCOME SYSTEM

Children's Performance Outcome Instruments

TABLE 2-1: List of Children's Performance Outcome Instruments

Required Children and Youth Instruments:	
<ul style="list-style-type: none"> <i>Child Behavior Checklist for Ages 4-18 (CBCL):</i> <u>Description:</u> Measures functioning on several dimensions including but not limited to functioning in school, home, and community settings; mental status; psychiatric disorders, and antisocial behavior from the parent's or caregiver's perspective. <u>Completed by:</u> Parent or primary caregiver (for clients age 4 through 18). 	
<ul style="list-style-type: none"> <i>Youth Self Report for Ages 11-18 (YSR):</i> <u>Description:</u> Measures functioning on several dimensions including but not limited to functioning in school, home, and community settings; mental status; psychiatric disorders, and antisocial behavior from the youth's perspective. <u>Completed by:</u> Child or adolescent clients (for clients age 11 through 18). 	
<ul style="list-style-type: none"> <i>Child & Adolescent Functional Assessment Scale for Ages 7-18 (CAFAS):</i> <u>Description:</u> Measures youth functional domains including role performance in school/work, home, and community; behavior towards others; moods; substance use, and thinking. <u>Completed by:</u> Clinician or other qualified mental health staff member (for clients age 7 through 18). 	
<ul style="list-style-type: none"> <i>Client Satisfaction Questionnaire (CSQ-8):</i> <u>Description:</u> Measures consumer satisfaction with services received. <u>Completed by:</u> Parent or primary caregiver (for clients of all ages). 	
<ul style="list-style-type: none"> <i>Client Living Environments Profile (CLEP):</i> <u>Description:</u> Indicator of type of living situation and restrictiveness of the living situation. <u>Completed by:</u> Clinician or other individual who possesses the information necessary to complete it (for clients of all ages). <i>Note: If this data is already being collected in another manner, this instrument may be omitted. However, the data must be summarized in the categories listed on the CLEP.</i> 	
Optional/Recommended Children and Youth Instruments:	
<ul style="list-style-type: none"> <i>Family Empowerment Scale (FES):</i> <u>Description:</u> Measures how a parent or caregiver of a child with an emotional problem feels about his or her role as a caregiver for the child. <u>Completed by:</u> Parent or primary caregiver (for clients of all ages). 	
<ul style="list-style-type: none"> <i>Youth Satisfaction Questionnaire (YSQ):</i> <u>Description:</u> Measures consumer satisfaction with services received. <u>Completed by:</u> Child or adolescent client (for clients age 9 through 18). 	

Sources of Instruments and Estimated Costs**TABLE 2-2: Authors, Sources and Estimated Costs for Each Instrument**

Instrument	Author/Source	Estimated Cost (per standard form)
CBCL*	Thomas Achenbach, Ph.D. Child Behavior Checklist 1 South Prospect Street Burlington, VT 05401-3456 Phone: (802) 656-8313 or -4563 Fax: (802) 656-2602	\$0.40
YSR*	Thomas Achenbach, Ph.D. Child Behavior Checklist 1 South Prospect Street Burlington, VT 05401-3456 Phone: (802) 656-8313 or -4563 Fax: (802) 656-2602	\$0.40
CAFAS*	Kay Hodges, Ph.D. 2140 Old Earhart Road Ann Arbor, MI 41805 Phone: (313) 769-9725 Fax: (939) 769-1434	\$0.40
CSQ-8*	Clifford Attkisson, Ph.D. University of San Francisco 500 Parnassus Ave., MU200-W San Francisco, CA 94143-0244 Phone: (415) 502-6173 Fax: (415) 502-6177	\$0.25
CLEP	Public Domain Calif. Dept. of Mental Health Phone: (916) 327-9282 Fax: (916) 322-1025	n/a
FES	Public Domain Calif. Dept. of Mental Health Phone: (916) 327-9282 Fax: (916) 322-1025	n/a
YSQ	Public Domain Calif. Dept. of Mental Health Phone: (916) 327-9282 Fax: (916) 322-1025	n/a
Total Cost for Instruments Per Single Administration:		\$1.45 (Approx.)

** NOTE: These instruments are copyrighted and may not be duplicated without the written permission of the author.*

County Implementation

Definition of Implementation

Each county is required to fully implement the Children and Youth Performance Outcome System no later than April 1, 1998. Implementation of the system is defined as:

- a) Clinicians are assuring the completion of the required performance outcome instruments: the Child Behavior Checklist, Youth Self-Report, Child and Adolescent Functional Assessment Scale, Client Living Environments Profile (or equivalent placement information), and the Client Satisfaction Questionnaire. For each child and adolescent client receiving services for at least 60 days, the instruments are to be administered at intake, annually, and at discharge;
- b) Clinicians are adequately trained so that they are able to understand and use the reports and data generated from the instruments to aid in treatment planning and service provision;
- c) Counties have an established methodology for using data from the performance outcome instruments for aiding in program evaluation and quality improvement;
- d) Counties are providing scored reports generated from the instruments to clinicians (and clients when appropriate) within two weeks of completion; and
- e) Counties have operationally established a system that will allow the county to provide specified reports and client level data in electronic format to DMH no later than June 1998.

Administration of Instruments

TABLE 2-3: Who Completes Each Instrument, Applicable Ages and Average Time

Instrument	To be Completed by:	Applicable Ages	Average Time for Completion
CBCL	Parent or Primary Caregiver	4-18	20 minutes*
YSR	Child or Adolescent	11-18	20 minutes*
CAFAS	Clinician	7-18	15 minutes
CSQ-8	Parent or Primary Caregiver	All	5 minutes
CLEP	Clinician or Other Staff w/Info.	All	5 minutes
FES	Parent or Primary Caregiver	All	15 minutes
YSQ	Child or Adolescent	9-18	10 minutes

- * This completion time assumes that the client and primary care giver are able to read and operate at a functional level that allows them to complete the forms without assistance. If assistance is required, the average time for administration of the CBCL and YSR could be as high as an hour for each instrument.

TABLE 2-4: Schedule for Administering the Instruments

Schedule	Instruments to Administer	When to Administer
Time 1	CBCL, YSR, CAFAS, CLEP	Within 60 days
Time 2	CBCL, YSR, CAFAS, CSQ-8, CLEP, FES*, YSQ*	Annually
Time 3	CBCL, YSR, CAFAS, CSQ-8, CLEP, FES*, YSQ*	Upon Discharge

* The FES and YSQ are optional and are recommended but not required to be administered.

Target population = Children receiving services for 60 days or longer
(those traditionally admitted to coordinated care)

The schedule for completing the full battery of instruments is: (1) within 60 days of the client's involvement with county mental health (sometimes referred to as "intake" for the target population), (2) annually (i.e., annual case review), and (3) upon discharge. With the elimination of the requirements for the completion of Coordinated Care Plans under the implementation of managed care, another mechanism may be established for identifying long-term or target population clients. However, at this time, the target population is defined as the children receiving services for 60 days or longer. The instruments should be administered as soon as it is determined the client is within the target population.

Reporting Performance Outcome Data

The data that will be generated from the Children and Youth Performance Outcome System will serve several primary purposes which include:

- Assisting clinicians with treatment planning and service provision;
- Effecting quality improvement in local mental health programs;
- Providing performance outcome data to the State and Legislature; and
- Allowing the comparison between California's public mental health programs and those of other states.

First, and perhaps most importantly, these instruments were selected for their potential utility to clinicians in assisting with treatment planning and service provision. In addition, an important purpose of the performance outcome data is to effect quality improvement in local mental health programs. Therefore, as part of its oversight process, the Department of Mental Health (DMH) will review each county's policies and procedures to ensure that a process exists whereby

performance outcome data are used to provide feedback to quality improvement staff and that methods are developed to effect program improvement based on these data.

In order to fulfill its statutory oversight responsibilities, the DMH will require that each county mental health program submit a set of client-level data in the format specified in the DMH Children and Youth Performance Outcome Data Dictionary. The method of entry and management of performance outcome data is at the discretion of each local program. However, the transmission of the data to the State will require that it be in established formats. Although specific time frames have not been established, it is likely that during the first full year of implementation, the data should be forwarded to DMH on a quarterly basis and thereafter it is to be provided on a semi-annual basis. Additionally, on an annual basis, each county mental health program will submit statistical reports containing average and standard deviation scores from each performance outcome instrument including scales and subscales by:

- Age;
- Ethnicity;
- Gender; and
- Diagnosis.

The DMH, in its oversight role, will review these data in conjunction with data contained in the Client Services Information System (CSIS). Counties will be asked for assistance in the interpretation of results relating to their own program performance. Reports will be generated comparing each county's mental health program performance to itself over time.

Frequently Asked Questions

- Why were these specific forms selected?

Most of these forms were selected because they are standardized instruments that are widely used, have been validity and reliability tested, and have acceptable psychometric characteristics.

- How with the forms be purchased and who pays for them?

Each county should purchase sufficient forms for all applicable children/youth clients, or require that their privately contracted providers purchase them directly. For System of Care Counties, the funds should be utilized from the grant monies. For non-System of Care Counties, DMH is examining the possibility of allocating some additional funding for the administration of two complete sets of instruments per client.

- Is the time associated with administering the instruments billable?

The administration and scoring of the performance outcome instruments may be billed by treatment providers as assessment.

- What should be done if a client and/or their caregiver refuse to fill out the instruments?

Clinicians and other mental health staff should encourage clients and family to complete the forms, however, if all attempts of explanation and encouragement fail, then include an explanation (such as “client/parent/other refused to complete”) in the file for auditing purposes. In all cases, however, the CAFAS can still be completed by the clinician based on the last interaction with the client.

- When should the instruments first be administered -- at the point when the client first starts receiving services, or at the end of 60 days and entry into coordinated care? (If the instruments are filled out after receiving treatment, it is possible they will be measuring, at least in part, the effect of having received services.)

The instruments should be administered as soon as it is determined the client is within the severely emotionally disturbed target population. If the client will be receiving services for more than 60 days, the instruments must be administered within 60 days from “intake”. Identification of the target population is an issue that will be reexamined in the future. At this time, it is acknowledged that this method of administration lacks the level of desired sensitivity regarding the initial treatment of services.

- What languages are each of the forms available in?

TABLE 2-5: Languages Available for Child/Youth Instruments

Instrument	Non-English Languages Available
CBCL	Albanian, Amharic, Arabic (West Bank), Armenian, Bahasa-Indonesia, Bengali, Cambodian, Czech, Dutch, English, Greek, Hebrew, Hindi, Hong Kong-Chinese, Hungarian, Italian, Japanese, Kiambu, Korean, Latvian, Lithuanian, Persian, Polish, Portuguese, Russian, Serbo-Croatian, Samoan, Slovenian, Spanish, Tagalog, Thai, Turkish, Vietnamese, Zulu
YSR	Amharic, Bahasa-Malaysia, Cambodian, Czech, Dutch, English, Greek, Hindi, Hong Kong-Chinese, Hungarian, Italian, Japanese, Korean, Persian, Polish, Portuguese, Russian, Samoan, Serbo-Croatian, Slovenian, Spanish, Tagalog, Turkish, Vietnamese
CAFAS	English only
CSQ-8	Cambodian, Chinese, Dutch, English, French, Korean, Spanish, Tagalog, Vietnamese (<i>Note: A Japanese version is under development.</i>)
CLEP	English, Spanish
FES	English, Spanish
YSQ	English, Spanish

- How will client confidentiality be ensured?

Steps are being taken to design systems that will ensure client confidentiality. Each client will be assigned a unique county identification code for the county to transmit the data files to the State without revealing the identify of the client. Secure data transmissions methods will be implemented. No analyses will be generated that report individual client data at the state level.

- Are these forms “culturally competent” and appropriate for use with California’s diverse population?

Unfortunately, there are no simple solutions to identifying or developing standardized assessment instruments that meet the modern conception of cultural competence. While it is possible to translate instruments into a given client’s language, and even though it is possible through statistical techniques to identify what a given cultural group’s scores mean in relation to other groups, it is difficult to conceptualize a single instrument that is appropriate for the interpersonal and cognitive styles of a wide variety of cultures. The State Department of Mental Health is working with counties to address the simpler questions first (i.e., appropriate language translations) and is committed to working with the California Mental Health Planning Council and California Mental Health Directors Association to identify ways to make the overall system truly culturally competent.

- Is there technical assistance available regarding data management/electronic transfer technologies?

The Research and Performance Outcomes Development Unit at the State Department of Mental Health is committed to providing county MIS staff with as much technical assistance as possible. The following assistance has been provided to date: 1) a children and youth data system is being developed that counties may use to manage their children’s performance outcome data; 2) staff have worked to identify and disseminate information on the strengths and weaknesses of systems that various counties are using to manage their performance outcome data; and 3) a children and youth performance outcome data dictionary has been developed and disseminated to all counties identifying the specific format and files names of all data counties are required to provide relating to children and youth performance outcomes. For more information on this, contact Sherrie Sala-Moore at (916) 445-6843.

SECTION 3 - PSYCHOMETRICS

General Information

The term “psychometrics” refers to the practice and technology of applying statistically-based techniques toward the measurement and understanding of psychological “events”. These events could include attitudes, personality traits, aptitudes and abilities, and underlying factors relating to psychological functioning. In a clinical setting, which by design is generally centered on a specific individual, some feel that using statistically based assessment tools is not appropriate. Rather, these individuals feel that it is the clinician’s professional judgment which grows out of the establishment of a relationship of mutual trust that is most important.

No reasonable psychometrician would claim that statistical data is more important than the relationship that exists between service provider and client. However, psychometric data can, if used appropriately, provide a very valuable piece of the puzzle that helps the clinician to develop a more complete picture of the client. Specifically, **psychometric data provides three essential components to the diagnosis, treatment planning, and service provision process:**

1) Well Defined Areas of Measurement

Scores that are derived from appropriately designed psychometric-based assessment instruments are generally well defined so that something meaningful can be said about a person based on his or her score on that instrument.

2) Reliability

There is evidence that the diagnostic process, when based on clinician judgment alone, is not particularly reliable. In other words, if several clinicians evaluate the same client using the same information, their diagnoses will likely differ to some degree. To the extent that specific diagnoses are more amenable to specific treatment modalities, arriving at an appropriate diagnosis is critical to providing the best service to clients. With psychometric-based data, it is possible to state, in a quantifiable way, how much confidence may be placed in scores that describe the client. This is not to say that those scores are necessarily a complete picture of the client, however. But when psychometric data are used in conjunction with a clinician’s clinical judgment, greater confidence may be placed in the overall treatment planning process.

3) Validity

The third and final essential component that psychometric data brings to the diagnosis, treatment planning, and service provision process is a quantifiable level of validity. Because of the intimate and person-centered nature of the clinician-client relationship, a wide variety of factors enter into the judgments made by the clinician about the client. For

example, the nature of the clinician's training will guide diagnostic procedures, and will likely lead to a focus on client behaviors that were emphasized in his or her training; the clinician's own recent and overall professional experience will affect how he or she approaches the client; because the clinician is human, it is likely that his or her own emotional state and personal beliefs will affect judgments made about the client; finally, the administrative environment in which the clinician works will likely place constraints on how the clinician-client relationship develops.

Because of the way that psychometric-based assessment instruments are developed, it is possible--within limits--to be sure that the instrument is mainly measuring what it is supposed to measure. This is referred to as "instrument validity." Stated in other terms, validity refers to the extent to which an instrument is measuring what it is supposed to measure and that the clinician can make appropriate judgments based on the instrument score(s).

Some Basic Concepts in Psychometrics

Reliability

Broadly defined, reliability simply refers to the confidence that you can have in a person's score. In some cases, you want to be able to have confidence that the individual would have the same score over time. This is because you have reason to believe that what is being measured should not change over time. For example, if a person passes a driving test in January it is hoped that the same individual would pass the test one year later. At other times, it may not be appropriate to expect that scores would remain consistent over time. For example, it is hoped that if a client receives treatment for depression, the score that the client would receive on a measure of depression should decrease over time. Psychometricians and other measurement specialists have developed various methods of establishing reliability to meet these varying needs. Some of these are listed below:

Test-Retest Reliability

In test-retest reliability methodologies, an assessment instrument is administered at time 1 and then again at some later date(s). To the extent that the scores that the client receives are the same on both administrations, the two sets of scores will be positively correlated. The correlation coefficient between these two administrations then becomes an estimate of the ability of the assessment instrument to reliably assess the client over time.

Problems with this approach: The main problem with the test-retest approach to establishing validity is that a wide variety of intervening variables can come into play between the first and subsequent administrations of the instrument. An example from the educational setting might be that a college entrance examination is administered to students

at the beginning of their Junior year of high school. If the same instrument were administered again at the end of those same students' senior year, the scores would likely be quite different due to all of the intervening learning that took place. From a psychological standpoint, if a person completed a measure of depression at time one and then experienced some major life event before the second administration of the measure, the estimate of the instrument's reliability would appear low. Finally, it is possible that, having completed the instrument one time the clinician's or client's responses may be affected at the second administration if he or she remembers the previous responses.

If, on the other hand, it is hypothesized that whatever the assessment instrument is measuring really should not change over time, then the test-retest approach is a powerful method of establishing this fact.

Parallel Forms Reliability

Another way of establishing reliability is to develop two forms of the same instrument. In theory, if the two forms are measuring the same thing (e.g., depression), then the scores on the two forms should be highly and significantly correlated. To the extent that they are in fact correlated, the correlation coefficient is roughly a measure of parallel forms reliability.

Problems with this approach: There are several problems with this method of establishing reliability. First, it can be expensive to develop two parallel forms. The second and perhaps greater problem is that there is always a certain amount of "criterion contamination" or variance that is unrelated to what is intended to be measured in an instrument score. This is compounded in that if there is a certain amount of unsystematic variance in each assessment instrument, then the sum of that variance across the two forms will reduce the reliability between the forms.

Split-Half Reliability

This method of establishing reliability is similar to the parallel forms method--but with one important difference. To use the split-half method, an assessment instrument is administered to a group of individuals. Next the instrument is essentially randomly divided into two equal portions. These two portions are then evaluated to examine how strongly they are correlated. Assuming that the instrument is measuring a common trait, ability, or psychological dimension, each half of the randomly divided instrument should be a measure of the same thing. Therefore, scores on each half should be highly correlated.

Problems with this approach: There are two main problems with this approach. First, when you divide the assessment instrument in half, you effectively reduce the number of items from which the total score is calculated by half. Thus, you may by nature have a score on each half that is of lower reliability and therefore any correlation between the two

halves could be reduced. Therefore, the overall estimate of reliability could appear inappropriately low. The second problem is that even though the assessment instrument was randomly divided, there is no guarantee that the two halves are actually equivalent. To the extent that they are not, the estimate of overall reliability will be lower.

Internal Consistency

The internal consistency approach to establishing reliability essentially evaluates the inter-item correlations within the instrument. Ultimately, an estimate of reliability is generated that is equivalent to the average of all possible split-half divisions that could have been made for that instrument.

TABLE 3-1: Summary of Reliability Methodologies

Method	Strengths	Weaknesses
Test-Retest Reliability	<ul style="list-style-type: none"> Correlates scores from two separate administrations of an instrument. Correlation coefficient estimates instrument's ability to reliably assess client over time. 	<ul style="list-style-type: none"> A wide variety of intervening variables between the first and subsequent administrations of the instrument could alter the results.
Parallel Forms Reliability	<ul style="list-style-type: none"> Correlates scores of two forms of an instrument designed to measure the same thing. Correlation coefficient estimates instrument's ability to measure the target domain. 	<ul style="list-style-type: none"> It can be expensive to develop two parallel forms. There is always a certain amount of variance unrelated to what is intended to be measured in an instrument score that would reduce the reliability between the forms.
Split-Half Reliability	<ul style="list-style-type: none"> Correlates scores for two equal, randomly divided portions of an instrument. Correlation coefficient estimates instrument's ability to measure the target domain. 	<ul style="list-style-type: none"> Since only 50% of the items are used per score, the overall estimate of reliability could appear inappropriately low. To the extent that the two halves are not equivalent, the estimate of overall reliability will be lower.
Internal Consistency	<ul style="list-style-type: none"> Evaluates the inter-item correlations within the instrument. An estimate of reliability is generated equivalent to the average of all possible split-half divisions. 	

Validity

Some people misuse the term “validity” when they refer to assessment instruments. It is inappropriate to say that an assessment instrument is valid. Rather, it is the inferences or decisions that are made on the basis of an instrument’s scores that are either valid or invalid. In order to be able to make valid inferences about a client based on his or her score on an instrument, the instrument must be measuring what it was intended to measure. This point cannot be emphasized enough.

When a client completes an instrument that is designed to evaluate his or her psychological functioning, if the instrument uses terms that, while common in a European cultural setting, may not be familiar in an Asian setting, then the inferences based on the instrument scores may not be appropriate for Asians. Threats to validity do not have to be nearly so extreme or obvious to make interpretation of scores invalid for making assessments. Therefore, it is important for users of test information to understand methods of test validation, the strengths and weaknesses of each, and what types of inferences are more appropriate for the method of validation that was used. Several validation methods are discussed briefly below.

Content Validity

When one says that an instrument is content valid, it indicates that the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. For example, in an instrument designed to measure quality of life, if that instrument contains items such as indicators of living situation, independence, self-sufficiency, etc. (assuming these have been documented by a group of individuals as measuring quality of life), then the instrument may arguably be called “content valid.”

Criterion-Related Validity

There are basically two methods of employing criterion-related validation strategies. These are: a) predictive and b) concurrent.

In predictive criterion-related validation strategies, the goal is to develop an instrument that is able to predict a person's later score, performance, or outcome based on some initial score. Examples of such predictive instruments include the General Aptitude Test Battery (GATB), Armed Services Vocational Aptitude Battery (ASVAB), Scholastic Aptitude Test (SAT), and Graduate Record Examination (GRE).

In concurrent criterion-related validation strategies, the goal is to effectively discriminate between individuals or groups on some current trait. For example, the Minnesota Multiphasic Personality Inventory (MMPI) was developed using a method called criterion keying to develop an instrument that was extremely powerful at identifying whether or not a person was currently experiencing psychoses.

The criterion-related validation approach can be extremely powerful. However, it suffers from a variety of conceptual and/or logistical problems. Although I will not delve deeply into the statistical reasons for these problems, I will list them. Using a criterion-related validation strategy:

- It is difficult to develop parallel forms.
- Instruments tend to have low internal consistency.
- To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion. This makes it methodologically difficult to identify test items.
- Instruments tend to have low face validity.

Construct Validity

Construct validation approaches utilize factor analysis to identify items that appear to be highly correlated to one another. To the extent that items are, in fact, correlated to each other they are assumed to be measuring something in common. Exactly what those items are measuring is difficult to say. What test developers do is review the content of the items and try to identify commonalities in the subject matter that they cover. For example, if a group of inter-correlated items addresses such things as sleeplessness, lack of energy, frequent crying, fear of being alone, etc., a test developer may decide that these items are measuring the construct of depression.

What is a construct? It is important to keep in mind that a construct does not exist. Rather, it is a theoretical creation to explain something that is observed. Returning to our example of a depression construct, depression is not a thing that exists. Rather, it is simply a name that we have given to a group of traits or a level of psychological functioning.

Face Validity

Face validity simply refers to the extent to which an assessment instrument “appears” to be related to what it purports to measure. For example, a driving test is face valid because all of the questions that are asked are related to laws and situations that a driver may be faced with. Therefore, even if we don’t like driving tests, most of us feel that they are at least somewhat related to driving.

On the other hand, someone may find that math ability is related to driving ability. If this occurred, it would be possible to administer a math test and, based on the scores a test taker received, either approve or deny a driver’s license. In this case, a math test could be valid for use in predicting driving behavior, but it would not be face valid because it would “appear” unrelated to the task of driving.

Face validity is important in most assessment settings because people inherently like to make sense out of what they are doing. When clinicians, clients, family members, or anyone else are asked to fill out an assessment instrument, they will feel better about doing so and will likely provide more accurate data if they feel that the information they provide makes sense and can see how it can be useful.

TABLE 3-2: Summary of Validation Methodologies

Method	Strengths	Weaknesses
Content Validity	<ul style="list-style-type: none"> Provides an indication of how the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. 	<ul style="list-style-type: none"> Assumes that the area being measured is clearly understood. To the extent that what is being measured is conceptual or multi-dimensional, effective content-oriented items may be difficult to develop.
Criterion-Related Validity	<ul style="list-style-type: none"> <i>Predictive strategies</i> provide an indication of how well the instrument is able to predict a <u>later</u> score, performance, or outcome based on some initial score. <i>Concurrent strategies</i> provide an indication of how the instrument effectively discriminates between individuals or groups on some <u>current</u> trait. 	<ul style="list-style-type: none"> It is difficult to develop parallel forms using this approach. Instruments tend to have low internal consistency. To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion making it methodologically difficult to identify test items. Instruments tend to have low face validity.
Construct Validity	<ul style="list-style-type: none"> Utilizes factor analysis to identify items that appear to be highly correlated to one another in order to develop assessment instruments that measure a common construct. 	<ul style="list-style-type: none"> Exactly what a group of inter-correlated items is measuring may be difficult to ascertain.
Face Validity	<ul style="list-style-type: none"> Provides an indication of how the assessment instrument “appears” to be related to what it purports to measure 	<ul style="list-style-type: none"> Not really an indicator of validity. Rather, it is based on the assumption that data will be more valid when respondents see the relationship between the instrument and what it is supposed to measure.

Conclusion

Psychometric data is intended to provide an additional tool for clinicians and other service providers to use as they plan and conduct their treatment. It is not intended to supplant or replace clinical judgment. The above issues have been discussed to help those who use data

generated from the Children and Youth Performance Outcome System evaluate and make more effective and appropriate use of their client's assessment data.

It is important to understand which method was used to validate each of the clinical assessment instruments so that you can know what kinds of judgments may be made about the scores. Knowing that an instrument is reliable and how the reliability was established can help the clinician have confidence in the scores as well as know what kinds of changes are reasonable to expect.

Finally, the remainder of this training document goes into additional detail on each of the assessment instruments. Each instrument's validity, reliability, administration and scoring procedures, interpretation, and use will be discussed. The above information is intended to help you make sense of this.

Sources of Further Information

Anastasi, A. (1982). Psychological Testing (5th. Ed.). New York: MacMillan.

Crocker, L. & Algina, J. (1986). Introduction to Classical and Modern Test Theory. Orlando, FL: Harcourt Brace Jovanovich College Publishers.

Holland, P. & Wainer, H. (1993). Differential Item Functioning. Hillsdale, NJ: Lawrence Erlbaum Associates

Kamphaus, R. (1993). Clinical Assessment of Children's Intelligence: A Handbook of Professional Practice. Needham Heights, MA: Allyn and Bacon, a Division of Simon and Shuster, Inc.

Nunnally, J. (1978). Psychometric Theory (2nd. Ed.). San Francisco: McGraw-Hill.

SECTION 4 - CLEP, CSQ-8, FES & YSQ

General Information

Client Living Environments Profile (CLEP)

The Client Living Environments Profile (CLEP) is a public domain instrument (it may be freely copied) that was developed by the Children's Performance Outcome Technical Work Group under the oversight of the Department of Mental Health. The CLEP is an indicator of the child's living situation and the restrictiveness of the living situation over the last 12 months. Specifically, the CLEP collects two kinds of information: 1) current living situation and 2) *predominant* living situation over the last twelve months. The CLEP is to be administered for all target population clients (see page 2-4 for description of target population) within 60 days of first receiving service, annually and at discharge.

Client Satisfaction Questionnaire (CSQ-8)

The Client Satisfaction Questionnaire (CSQ-8) was developed, validated and copyrighted by Clifford Attkisson, Ph.D., a professor at the University of California at San Francisco. Dr. Attkisson is also an associate of Abram Rosenblatt, Ph.D., who is the contract evaluator for Children's Systems of Care and who also was the architect of the model we are using for the Children and Youth Performance Outcome System. The CSQ-8 is to be completed by the parent/primary caregiver and was designed to rate the level of satisfaction with the services provided for their child using a Likert-type (5-point) rating scale. The CSQ-8 is to be administered for all target population clients (see page 2-4 for description of target population) annually and at discharge.

Family Empowerment Scale (FES)

The Family Empowerment Scale (FES) is a public domain instrument (it may be freely copied) and has been used in evaluation research conducted by the Regional Research Institute for Human Services at Portland State University in Oregon. The FES is designed to measure parents' or family caregivers' attitudes, knowledge and behavior related to their power to get effective care for their child and participate in community and political change in children's mental health systems. The instrument contains 34 straightforward items (e.g., "I am able to get information to help me better understand my child") that are rated on a 5-point scale from "not true at all" to "very true". The FES is recommended, but not required, to be administered for all target population clients (see page 2-4 for description of target population) annually and at discharge.

Youth Satisfaction Questionnaire (YSQ)

The Youth Satisfaction Questionnaire (YSQ) is a public domain instrument (it may be freely copied) and has been used in the evaluation of a community-based case management program that provides individualized services to seriously emotionally disturbed children. The YSQ is designed to measure both the child's general level of satisfaction with services and their satisfaction with specific services they have received. The instrument contains 5 general questions (e.g., "Did you like the help you were getting?") with answers rated as "yes", "somewhat" or "no"; and has a section where specific services can be entered into blank spaces to be rated with a grade from A to F to rate the quality of care. The YSQ is designed to be completed by a child or adolescent client 9 years of age or older. The YSQ is recommended, but not required, to be administered for all target population clients (see page 2-4 for description of target population) age 9 or older annually and at discharge.

Administration*Who Should Administer the CLEP, CSQ-8, FES & YSQ Instruments?*

The CLEP may be administered by any mental health staff person who possesses the information necessary to complete it. The CSQ-8, FES and YSQ instruments are designed to be self-administered or administered by an interviewer if the respondent requires assistance or if there are language barriers.

Instructions for the Client Living Environments Profile (CLEP)

- 1) Select one of the codes from Table 4-1 that is most representative of the client's living environment at the time of assessment.
- 2) Select one of the codes from Table 4-1 that is most representative of the client's predominant placement over the past 12 months.

TABLE 4-1: CLEP Living Environment Codes

Environment Code	Living Environment Category
1	Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)
2	Psychiatric Hospital or Residential Treatment Center (Levels 13-14)
3	Group Home (Levels 1-12)
4	Foster Care or Therapeutic Foster Care
5	Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting.
6	Living Independently by Self, with Spouse, Roommate, and/or Dependent Children.

7	Homeless
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Note: The State does not require the actual use of the CLEP instrument if this data is already being collected in another manner. However, the client's living environment data must be forwarded to the State in the designated categories listed in Table 4-1. This would require recoding of the county's current living situation data. If the Restrictiveness of Living Environments Scale (ROLES) is being used, refer to page 30 of the Data Dictionary for the Children and Youth Performance Outcome Data System for a ROLES to CLEP Conversion Chart. Contact Sherrie Sala-Moore at (916) 445-6843 if questions arise regarding recoding this data.

Instructions for the Client Satisfaction Questionnaire (CSQ-8)

The Department of Mental Health, acting on the recommendations of the Performance Outcome Advisory Group (POAG), is requiring the following administration criteria regarding the CSQ-8:

1. Counties must chose to either:
 - a) Provide the client's identification code with each client's CSQ-8 data.

OR

 - b) The county must collect the following demographic information as part of the CSQ-8 survey:
 - 1) gender,
 - 2) ethnicity,
 - 3) age, and
 - 4) method of administration.
2. With respect to how the CSQ-8 is administered, the Department of Mental Health is encouraging flexibility. The goal is to find those strategies that maximize return rates and facilitate valid data without causing an unnecessary burden to county staff. Therefore, the Department of Mental Health is requiring that whatever strategy is used to administer the CSQ-8 (e.g., mail-out, peer administration, hand out prior to receiving treatment and drop in a locked box, etc.) the method of administration be included in the data files sent to the state. See the Children and Youth Performance Outcome System Data Dictionary for additional information on the structure and format of the data set to be sent to the State.
3. Finally, it is imperative that client confidentiality be assured as part of the process of collecting consumer satisfaction data. Therefore, it is recommended that when a client is sent or handed a satisfaction survey, a notice of confidentiality of data be included to reassure the client.

Instructions for the Family Empowerment Scale (FES)

The FES is completed by the client's parent or primary care giver. Since this is not a mandatory instrument for use in Children and Youth Performance Outcomes, no specific scoring

and administration instructions shall be provided. Rather, the instrument should be used, if at all, in the manner that the county feels it will provide the most benefit.

Instructions for the Youth Satisfaction Questionnaire (YSQ)

The YSQ is completed by the client's parent or primary care giver. Since this is not a mandatory instrument for use in Children and Youth Performance Outcomes, no specific scoring and administration instructions shall be provided. Rather, the instrument should be used, if at all, in the manner that the county feels it will provide the most benefit.

Confidentiality

To encourage accurate responses, it is crucial that respondents for the CSQ-8, FES and YSQ instruments be assured confidentiality of their responses so they will not have any fear of retribution. **The CSQ-8, FES and YSQ instruments should never be returned to the clinician.** It is recommended that these instruments be placed in a sealed envelope after completion by the respondent.

A county may want to provide an "Assurance of Confidentiality" letter along with the instrument when given to the respondents. The following is an example of the text of such a letter:

"This letter is to assure you as a client receiving mental health services through [insert your agency name] that the Client Satisfaction Questionnaire, the Family Empowerment Scale, or the Youth Satisfaction Questionnaire that you are about to fill out is confidential. Your therapist will not see this and your responses will in no way affect your right to service. Because [insert county name] County will use the results to improve quality of service, we are interested in your honest opinions, whether they are positive or negative. Thank you for your cooperation and help in improving our service to you."

Frequently Asked Questions

- How do I obtain copies of the public domain instruments?

Master copies of the CLEP, FES, and YSQ may be obtained from the Department of Mental Health. Contact Susan Burgess at (916) 327-9282.

- If these instruments are optional, why should they be used?

One of the values that we hold as very important to the public mental health system is that the client and his or her family be involved in the treatment process. The family empowerment scale collects information from the parent or primary care giver

relating to the extent to which he or she feels enabled to truly participate in and shape the treatment process.

Currently, client satisfaction with services is only collected from the parent or primary care giver in the Children and Youth Performance Outcome System. This is done through the Client Satisfaction Questionnaire (CSQ-8). It can also be helpful to collect information on the degree to which the child or adolescent client is satisfied with services. The Youth Satisfaction Questionnaire (YSQ) is designed to collect the latter information. Together, these optional instruments along with the core battery of instruments provides comprehensive information about the client from the clinician, the client, and his or her primary care giver.

- Will data from the FES and YSQ be reported to the State?

No. The State will only be collecting the information from the core battery of instruments (i.e., CBCL, YSR, CAFAS, CSQ-8, CLEP). The specific information that the State will receive, as well as the format that it must be in when transmitted to the State, is clearly defined in the Children and Youth Performance Outcome Data Dictionary.

Sources of Further Information

Attkisson, C. Clifford, (1982), The Client Satisfaction Questionnaire: Psychometric Properties and Correlations with Service Utilization and Psychotherapy Outcome. Evaluation and Program Planning, Vol. 5, pp. 233-237.

Attkisson, C. Clifford & Greenfield, Thomas K., (copyrighted 1995), The Client Satisfaction Questionnaire (CSQ) Scales: A History of Scale Development and A Guide for Users.

For additional information on the FES & YSQ, contact the Regional Research Institute for Human Services, Portland State University, OR 97297, (503) 725-4040.

Ordering Information for the CSQ-8:	University of San Francisco, Professor of Medical Psychology ATTN: Clifford Attkisson, Ph.D. 500 Parnassus Ave. MU200-W, San Francisco, CA 94143-0244 Phone: (415) 502-6173 FAX: (415) 502-6177
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Ordering Information for the CLEP, FES & YSQ:	Department of Mental Health Research and Performance Outcome Development 1600 9th Street, Sacramento, CA 95814 Phone (916) 327-9282 FAX (916) 322-1025
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Client Living Environments Profile (CLEP)

Client Name:		Case Number:	County ID:
Gender:	Age:	Date of Administration	
Type of Administration: <input type="checkbox"/> Intake <input type="checkbox"/> 6 Month <input type="checkbox"/> 12 Month <input type="checkbox"/> Discharge			

Instructions:

Circle the number that corresponds to the category which most closely matches the client's **PREDOMINANT** living situation over the last 12 months. In cases where the client had more than one living situation during the last 12 months, try to choose the environment where he or she spent the longest amount of time.

Next, circle the number that corresponds most closely to the client's **CURRENT** living environment.

Environment Code		Living Environment Category
Predominant	Current	
1	1	Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)
2	2	Psychiatric Hospital or Residential Treatment Center (Levels 13-14)
3	3	Group Home (Levels 1-12)
4	4	Foster Care or Therapeutic Foster Care
5	5	Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting.
6	6	Living Independently by Self, with Spouse, Roommate, and/or Dependent Children.
7	7	Homeless

CLIENT SATISFACTION QUESTIONNAIRE © CSQ-8

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you have received?

4	3	2	1
<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
2. Did you get the kind of service you wanted?

1	2	3	4
<i>No, definitely not</i>	<i>No, not really</i>	<i>Yes, generally</i>	<i>Yes, definitely</i>
3. To what extent has our program met your needs?

4	3	2	1
<i>Almost all of my needs have been met</i>	<i>Most of my needs have been met</i>	<i>Only a few of my needs have been met</i>	<i>None of my needs have been met</i>
4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>
5. How satisfied are you with the amount of help you have received?

1	2	3	4
<i>Quite dissatisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Mostly satisfied</i>	<i>Very satisfied</i>
6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
<i>Yes, they helped a great deal</i>	<i>Yes, they helped somewhat</i>	<i>No, they really didn't help</i>	<i>No, they seemed to make things worse</i>
7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
<i>Very satisfied</i>	<i>Mostly satisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Quite dissatisfied</i>
8. If you were to seek help again, would you come back to our program?

1	2	3	4
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>

The Client Satisfaction Questionnaire (CSQ) was developed at the University of California San Francisco (UCSF) by Drs. Clifford Attkisson and Daniel Larsen in collaboration with Drs. William A. Hargreaves, Maurice LeVois, Tuan Nguyen, Robert E. Roberts and Bruce Stegner. Every effort has been made to publish information and research on the CSQ for widest possible dissemination. Proceeds from the publication of the CSQ will be used to support postdoctoral training, student academic affairs, and health and human services research activities.

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UCSF

University of California San Francisco

Family Empowerment Scale

Client Name:		Case Number:	County ID:
Gender:	Age:	Date of Administration	
Type of Administration: <input type="checkbox"/> Entry <input type="checkbox"/> 6 Month <input type="checkbox"/> 12 Month <input type="checkbox"/> Discharge			

Instructions:

Below are a number of statements that describe how a parent or caregiver of a child with an emotional problem may feel about his or her situation. For each statement, please circle the response that best describes how the statement applies to you.

Questions	Ratings (Circle your answers)				
1) I feel that I have the right to approve all services my child receives.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
2) When problems arise with my child, I handle them pretty well.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
3) I feel that I can have a part in improving services for children in my community.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
4) I feel confident in my ability to help my child grow and develop.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
5) I know the steps to take when I am concerned my child is receiving poor services.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
6) I make sure that professionals understand my concerns about what services my child needs.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
7) I know what to do when problems arise with my child.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
8) I get in touch with my legislators when important bills or issues concerning children are present.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
9) I feel my life is under control.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
10) I understand how the service system for children is organized.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
11) I am able to make good decisions about what services my child needs.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
12) I am able to work with agencies and professionals to decide what services my child needs.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
13) I make sure that I stay in regular contact with professionals who are providing services to my child.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
14) I have ideas about the ideal service system for children.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
15) I help other families get the services they need.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
16) I am able to get information to help me better understand my child.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
17) I believe that other parents and I can have an influence on services for children.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True

Questions	Ratings (Circle your answers)				
18. My opinion is just as important as professionals' opinions in deciding what services my child needs.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
19. I tell professionals what I think about services being provided to my child.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
20. I tell people in agencies and government how services for children can be improved.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
21. I believe that I can solve problems with my child when they happen.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
22. I know how to get agency administrators or legislators to listen to me.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
23. I know what services my child needs.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
24. I know what the rights of parents and children are under special education laws.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
25. I feel that my knowledge and experience as a parent can be used to improve services for children and families.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
26. When I need help with problems in my family, I am able to ask for help from others.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
27. I make efforts to learn new ways to help my child grow and develop.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
28. When necessary, I take the initiative in looking for ways to help my child grow and develop.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
29. When dealing with my child, I focus on the good things as well as the problems.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
30. I have a good understanding of the service system that my child is involved in.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
31. When faced with a problem involving my child, I decide what to do and when to do it.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
32. Professionals should ask me what services I want for my child.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
33. I have a good understanding of my child's disorder.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True
34. I feel that I am a good parent.	Not true at all	Mostly Not True	Somewhat True	Mostly True	Very True

Youth Satisfaction Questionnaire (YSQ)

(For Children Age 9 or Older)

Client Name:		Case Number:	County ID:
Gender:	Age:	Date of Administration	
Type of Administration: <input type="checkbox"/> 6 Month <input type="checkbox"/> 12 Month <input type="checkbox"/> Discharge			

Instructions:

Please help us to make this program better by answering the following questions about the services you received over THE LAST 12 MONTHS. We want to know how you felt, good or bad. Please answer all of the questions. Thank you!

Questions	Ratings (Circle your answers)		
Did you like the help you were getting?	Yes	Somewhat	No
Did you get the help you wanted?	Yes	Somewhat	No
Did you need more help than you got?	Yes	Somewhat	No
Were you given more services than you needed?	Yes	Somewhat	No
Have the services helped you with your life?	Yes	Somewhat	No

Now we would like you to grade the specific services YOU RECEIVED OVER THE LAST 12 MONTHS. Write the type of service below and circle a grade to rate how good you felt the service was.

Type of Service	Grade You Would Give The Service (Circle the grade)				
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F
	A	B	C	D	F

SECTION 5 - CBCL & YSR

General Information

The Child Behavior Checklist/4-18 (CBCL), the Youth Self-Report (YSR), and the Teacher's Report Form (TRF) were developed by Thomas M. Achenbach, Ph.D., to create standardized procedures for assessing children's competencies and problems. The 1991 edition of the CBCL and the YSR are the most current versions available. To facilitate comparison among reports completed by different informants regarding the same client, the 1991 profiles for the CBCL and YSR display eight scales which identify cross-informant problem syndromes. The CBCL and YSR are intended to serve as components of a multi-axial empirically-based assessment, an approach which emphasizes the use of multiple sources of data. Other components include teacher-reports, standardized tests, physical assessment, observations, and interviews. For the purpose of performance outcomes reporting, the CBCL should be completed for Seriously Emotionally Disturbed (SED) children and adolescent clients age 4 through 18, and the YSR should be completed for SED clients age 11 through 18.

Development Approach

To develop standardized procedures for assessing behavioral/emotional problems, descriptions of competencies and problems that are most often of concern to parents and mental health professionals were identified. These competency and problem types were derived based on earlier studies, clinical and research literature, and consultation with clinical and developmental psychologists, child psychiatrists, and psychiatric social workers. After successive revisions of pilot editions of the CBCL and YSR that were used in clinical settings, the competency and problem items were finalized into the format found in the current editions of the CBCL and YSR.

Validity and Reliability

Note: Refer to Section 3 for details on validity and reliability methodologies.

Validity pertains to the accuracy with which a procedure measures what it is supposed to measure and the extent to which confidence may be placed in inferences made on the basis of instrument scores or other data. Evidence supports the validity of the CBCL and YSR scores for content, construct, and criterion related validity. Content validity refers to whether an instrument's content includes items that are related to the area being assessed. The content validity of the CBCL/YSR is supported by the ability of most CBCL and YSR items to discriminate significantly between demographically matched referred and non-referred children.

Construct validity refers to whether a set of items represent or measure a single hypothetical variable. Construct validity of the CBCL/YSR is supported by numerous correlates of the

scales, including significant associations with analogous scales of other correlated instruments (e.g., the Quay-Peterson (1983) *Revised Behavior Problem Checklist*). The syndromes were empirically derived from through principal components analysis and factor analysis studies.

Criterion related validity refers to ability to make predictive decisions based on the score on an instrument. Criterion related validity of the CBCL/YSR is supported by the ability of the CBCL's and YSR's quantitative scores to discriminate between referred and non-referred children after demographic effects were partialled out. Clinical cutpoints on the scale were also shown to discriminate significantly between demographically matched referred and non-referred children.

Reliability refers to agreement between repeated assessments of phenomena when the phenomena themselves remain constant. The degree of inter-interviewer reliability and test-retest reliability were analyzed for the CBCL and YSR. Inter-interviewer reliability refers to the degree to which different interviewers obtain similar results. Test-retest reliability refers to the degree to which the same informants provide the same scores over periods when the subjects' behavior is not expected to change. The reliability correlations for the CBCL and YSR are summarized below in Table 5-1. The inter-interviewer and test-retest reliabilities of the CBCL item scores were supported by intra-class correlations for the mean item scores obtained by different interviewers and for reports by parents on two occasions 7 days apart. The test-retest reliability of CBCL and YSR scale scores were supported by the mean test-retest correlations obtained over a 7 day period for both the competence scales and for the problems scales.

TABLE 5-1: CBCL & YSR Reliability Correlations

<i>Type of Reliability</i>	<i>CBCL Correlations</i>	<i>YSR Correlations</i>
Inter-Interviewer & Test-Retest	0.90s	---
Test-Retest on Competence Scales	0.89	0.68 (11-14 Year Olds) 0.82 (15-18 Year Olds)
Test-Retest on Problem Scales	0.82	0.65 (11-14 Year Olds) 0.83 (15-18 Year Olds)

Scales and Definitions

Competence Scales

A total competence score for the CBCL is derived by summing the three competence scales which include Activities, Social, and School. The YSR total competence score is the sum of the scores for the Activities and Social scales, plus the mean score for ratings of performance in academic subjects.

TABLE 5-2: Competence Scales

<i>CBCL</i>	<i>YSR</i>
Activities	Activities
Social	Social
School	---

Problem Scales

There are eight cross-informant syndrome scales designated which include Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior. In addition, two broad groupings of syndromes are designated as Internalizing and Externalizing. The Internalizing score is the sum of the Withdrawn, Somatic Complaints and Anxious/Depressed scale scores. The Externalizing score is the sum of the Delinquent Behavior and Aggressive Behavior scale scores.

TABLE 5-3: Cross-Informant Problem Syndrome Scales

<i>Internalizing Group</i>	<i>Other</i>	<i>Externalizing Group</i>
Withdrawn	Social Problems	Delinquent Behavior
Somatic Complaints	Thought Problems	Aggressive Behavior
Anxious/Depressed	Attention Problems	---

Clinical Utility

The CBCL and YSR provide a structured, valid, and reliable way for collecting client data in a standardized format, which may assist clinicians in obtaining information that could be missed in an unstructured clinical interview process. Additionally, using the CBCL and YSR profiles provides the clinician with a graphical presentation of the child's areas of competence and areas of problems. This information can be used with and compared to the Child and Adolescent Functional Assessment Scale (CAFAS) profile which provides the clinician with a graphical presentation of the child's levels of functioning in a variety of domains, in order to obtain a more complete picture of how the child is functioning.

The CBCL and YSR profiles provide quantitative data which compares the client's functioning level both with a "normal" child population and with a nationwide clinically referred population. In addition, a comparison of the children in county programs could be made on a countywide basis. The instrument and profile data may be used to assist in validating the clinicians own judgment; they may assist the clinician in tailoring interventions to the child's specific needs; they can be used to provide structure to the goal setting process by identifying specific areas to target for improvement; and further, they provide a structured method to track improvements in specific areas over time.

How to read the Profile

A two page computer-scored profile is generated for both the CBCL and YSR. One page shows the client's "Competence" in several living areas and the other identifies "Problems" in various functional domains. The profile gives the clinician a picture of the child's overall functioning in various areas thought to be important in evaluating a child's competencies and problems. Each scale has a score indicated by three ###'s on the graph (see example profiles on pages 5-21 through 5-24). By drawing a line to connect these ###'s together, the profile provides a picture of the child's functioning in these areas as compared to the total population of children of the same age and sex.

Problem Scales

At the bottom of the profile are the names of the scales that have been scored for the client. For example, on the Competence page of the CBCL profile, Activities, Social and School are scored. On the Problems page of the CBCL profile, Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior are scored. The items comprising each of the eight scales are listed on the bottom half of the page. To the left of each problem type is the score (0,1, or 2) given the item by each respondent. The total scale score and two types of "T" scores are printed beneath each scale. T scores are scores that have been transformed to have a mean (average) of 50 and a standard deviation of 10. The first of these T scores (labeled "T SCORE") is in relation to non-clinical normative samples. The second type of T score (labeled "CLIN T") is derived from comparison of the child with a clinical population of children who had been referred for mental health services.

Internalizing/Externalizing Groupings

At the top of the Problems page of the profile, there are internalizing and externalizing broad-band syndrome groupings listed (see example profile on page 5-22). The internalizing syndrome grouping is comprised of three subscales: 1) Withdrawn, 2) Somatic Complaints and 3) Anxious/Depressed. The externalizing syndrome grouping is comprised of two subscales: 1) Delinquent Behavior, and 2) Aggressive Behavior.

Graph Nomenclature

The right axis of the graph lists normalized T scores with a mean of 50 and a standard deviation of 10. A T score of 60 represents 1 standard deviation above the mean.

The left axis of the graph lists percentile rankings. A ranking in the 85th percentile represents a score higher than 84% of the children tested and lower than 15% of the children tested.

The set of broken lines indicate the ranges for clinical, borderline and non-clinical scores. For the problems graph, scores above the top broken line (at the 98th percentile and T score of 70) represent the clinical population, scores within the two lines represent the borderline clinical

population, and scores below the bottom line represent the non-clinical population. For the competence graph, scores above the top broken line represent the non-clinical population, scores within the two lines represent the borderline clinical population, and scores below the bottom line (at the 2nd percentile and T score of 30) would represent the clinical population. Reminder: Higher competence scores indicate better functioning, clinical level is below the lower line. Higher problem scores indicate more severe problems, clinical level is above the top line.

Total Scores

To the right of the problems graph, various total scores are presented. The total number of problem items scored as present is listed (labeled “# ITEMS”). A total problem scores is listed (labeled “TOTSCORE”), as well an internalized score (labeled “INTERNAL”) and an externalized score (labeled “EXTERNAL”). T scores comparing these last three sums to the normative samples of non-referred children are presented under the appropriate sum (“TOT T”, “INT T”, and “EXT T”). If a T score falls in the borderline range, it is preceded by a “+”; if it falls in the clinical range, it is preceded by a “++”.

Additional Syndromes

On the CBCL for boys and girls age 4 through 11, a Sex Problems syndrome Total and T score are provided in a separate box near the bottom of the second page, below Syndrome VII, and is labeled as “IX”. This syndrome is comprised of problem items 5, 59, 60, 73, 96 and 110 which are marked with a “\$” where they appear.

On the YSR for boys only, a Self-Destructive/Identity Problems syndrome Total and T score are provided in a separate box at the bottom right corner of the second page, and is labeled as “IX”. This syndrome is comprised of problem items 5, 12, 13, 18, 20, 27, 33, 35, 57, 79, 91 and 110 which are marked with a “\$” where they appear.

Other Information

On the right of the problems page, below the total scores, is a list of “Other Problem” items which did not correlate highly with the eight syndrome scales but are informative to clinicians and other mental health workers.

Items that are not on the cross-informant construct are marked with an asterisk “*”. These represent differences between the items comprising the CBCL and YSR syndrome scales.

At the bottom of the problems page, data is displayed regarding relations between the child’s pattern of syndromes derived from cluster analyses of children referred for mental health services. These patterns are designated as Profile Types which include Withdrawn, Somatic Complaints, Social Problems, and Delinquent-Aggressive. Under each profile type is displayed

the intraclass correlation (ICC) between the child's clinical T scores and the clinical T scores that define each profile type for the child's age and sex. Two asterisks ("**") are printed next to the ICC if it is statistically significant.

The Socially Desirable items on the YSR (Items 6, 15, 28, 49, 59, 60, 73, 78, 80, 88, 92, 98, 106, 107, 108 and 109) are not counted toward the Total Problem score and they do not appear on the profile.

Interpretation of Scores

Each scale is generally self-explanatory and was developed to be descriptive of a youth's functioning. For example, the Withdrawn scale measures levels of withdrawal from interpersonal and social interactions. By reading the questions listed in abbreviated form below each scale, you can see the various components of your client's ratings on this scale. For each item, the informant has indicated if this statement is very true (2), somewhat true (1), or not true (0) about the client.

Each youth receives a raw score on each scale, indicated by the ### signs. It is a total of the numerical ratings of the statements comprising the scale. A T score of 70 (98th percentile) or higher or 30 (2nd percentile) or lower, on one or more of the scales is within a clinically significant range. This range falls two standard deviations above or below the mean on that scale and is in the top or bottom 2% of individuals being tested. It is unlikely that a score in this range is a chance finding or the result of testing error. Such a score generally indicates significant ability or disability, depending on what is being measured.

If a client has a T score of 80 in the area of aggressive behavior on the CBCL, for example, this is equivalent to the 99th percentile. It shows that the client has more problems with his/her aggression (as rated by the caregiver) than 99% of the total population of youth of his/her age and sex. If your client has a T score of 20 on the Activities Competency scale, this indicates they rated at the 1st percentile for youth of his/her age and sex in terms of involvement in activities (as rated by the caregiver).

Tips for analyzing the profile:

- Look first at the low points on the competency scale and the high points on the problems scale. These are an indication of the client's problem areas.
- If the client has scored in the clinical or borderline range in one or more areas, this should be noted.
- Take the informant (e.g., youth, parent, caregiver, or teacher) into account when analyzing the profile. It is important to be aware of a respondent's attitude, culture, agenda, perspective on life, as well as whether or not the client is self-referred or referred by the courts or another entity.
- If you have more than one informant (e.g., youth and mom), see if the scores are similar or different.

- For further information about a particular problem scale, look down the sheet for actual items which contributed to your client's score. By noting which items the client received high scores on, you will be able to identify specific problem areas.
- Look at the overall profile. In what areas does the youth have difficulties or strengths? Look for a pattern and see how it fits with and either confirms or conflicts with your picture of the youth. For example, if your client scores very high on delinquent behavior and aggressive behavior and in the low range on withdrawn, somatic complaints, and anxious/depressed, a "picture" of how the client function emerges -- externalizes anger, antisocial, feels minimal internal/psychological pain.
- Ask parent/youth for clarification on certain reported items, especially such items as number nine, "9. *Can't get mind off certain thoughts, obsessions*"; "40. *Hears sounds or voices that aren't there*"; "70. *Sees things that aren't there*"; "84. *Strange behavior*"; and "85. *Strange ideas*".
- Review the actual answer sheet for the CBCL and YSR. These forms requested the respondents to provide narrative descriptions to support or explain their responses on certain items.

Administration Procedures

Instructions

The parent/primary caregiver is to complete the CBCL for clients age 4 through 18. The child/youth is to complete the YSR for clients age 11 through 18. **It is important that the completion of each of these instruments are conducted independently of one another.**

To ensure that the respondent can read and that they understood the instructions on how to complete the instrument, some clinicians have recommended having them read the first question aloud and then state how they would score it. The clinician, or whoever is administering the instrument, can then determine if further assistance is required.

Who can administer the CBCL and YSR?

The CBCL and YSR are designed to be either self-administered or administered by an interviewer if the respondent requires assistance or if there are language barriers.

Where do the profiles go?

The profiles need to be sent back to the clinician within 2 weeks to review and use in treatment planning. Copies of the profiles should be filed in the client's permanent file.

Frequently asked questions

- Who do you give the CBCL to when no primary care giver is available, or when the client has just been released from a restrictive out-of-home placement (e.g., California Youth Authority, etc.)?

If there is no primary care giver to complete this instrument, the clinician/mental health staff should use their best judgment based upon the specifics of each situation. If a cooperative surrogate (such as a probation officer, group-home staff, etc.) can be found that could provide the type of information requested on the form, the clinician may want to administer the instrument accordingly. If no party is available with the required information, the only viable option would be include an explanation (such as “no one is available to provide this information”) in the file for auditing purposes.

- How should the CBCL be introduced to Parents/Primary Caregivers?

The CBCL should be introduced as a method of collecting information about the child who is receiving services. The exact language of the introduction should depend on knowledge of the family. This is an example of one county’s basic approach: *“Please complete this questionnaire about your child’s strengths and weaknesses. This will help us better understand what is going on so that we can provide the best type of help for your child. Please answer all questions and feel free to ask for help or clarification.”*

- How should the YSR be introduced to the youth?

The YSR should be introduced as a method of collecting information from the adolescent who is receiving services. The exact language of the introduction should depend on knowledge of the youth. This is an example of one county’s basic approach: *“Please complete this questionnaire about your strengths and weaknesses. This will help us better understand what is going on for you so we can provide the best type of help. Please answer all the questions and feel free to ask for help.”*

- In some instances, due to the minimal level of functioning or reading ability of the client and/or caregiver, the instruments cannot be completed independently. Are there alternative methods of administration that could reduce the amount of clinician time to administer the instruments in such situations?

Some alternative methods that counties are exploring include:

- Administering the instruments in a classroom type of setting;
- Using an video tape presentation to administer; and
- Creating a computerized system to administer.

Sources of Further Information

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M. (1991). *Manual for the Youth Self Report and 1991 Profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M. (1997). *Bibliography of Published Studies Using the Child Behavior Checklist & Related Materials: 1997 Edition*. Burlington, VT: University of Vermont Department of Psychiatry.

Ordering Information:

Child Behavior Checklist
University of Vermont
Department of Psychiatry
1 South Prospect Street
Burlington, VT 05401-3456

Phone: (802) 656-8313 or -4563
Fax: (802) 656-2602
E-Mail: Checklist@uvm.edu
Web: <http://www.uvm.edu/~cbcl/>

1997 ORDER FORM FOR CHILD BEHAVIOR CHECKLIST & RELATED MATERIALS

To hand score C-TRF, CBCL/2-3, CBCL/4-18, YSR, TRF, YASR, YABCL, you need: Forms, Profiles, Templates (not for SCICA or DOF).

To computer score you need: Forms or Client-Entry Program, plus scoring program.

	Item	Price	Quantity	Cost
SAMPLE PACK. Forms, profiles, instructions for C-TRF; CBCL/2-3 & 4-18; TRF; YSR; SCICA; DOF; YASR; YABCL	1955	\$20		
YOUNG ADULT SELF-REPORT. Classic forms completed by 18-30-year-olds	11004	25 for \$10		
PROFILES FOR HAND-SCORING OF YASR. (Same for both genders)	11104	25 for \$10		
TEMPLATES FOR HAND-SCORING OF YASR PROFILES. (Same for both genders)	11204	\$7		
YOUNG ADULT BEHAVIOR CHECKLIST. Classic forms completed by parents	12004	25 for \$10		
PROFILES FOR HAND-SCORING OF YABCL. (Same for both genders)	12104	25 for \$10		
TEMPLATES FOR HAND-SCORING OF YABCL PROFILES. (Same for both genders)	12204	\$7		
MANUAL FOR THE YASR AND YABCL. 207 pp	11500	\$25		
COMPUTER PROGRAM FOR SCORING OF YASR & YABCL	11626	\$220		
CAREGIVER-TEACHER REPORT FORM FOR AGES 2-5. Classic forms completed by daycare providers & preschool teachers	9004	25 for \$10		
PROFILES FOR HAND-SCORING OF C-TRF. (Same for both genders)	9104	25 for \$10		
TEMPLATES FOR HAND-SCORING OF C-TRF PROFILES. (Same for both genders)	9204	\$7		
GUIDE FOR THE C-TRF AND PROFILE	9500	\$10		
COMPUTER PROGRAM FOR SCORING OF C-TRF	9624	\$135		
CHILD BEHAVIOR CHECKLIST FOR AGES 2-3. Classic forms completed by parents	6004	25 for \$10		
PROFILES FOR HAND-SCORING OF CBCL/2-3. (Same for both genders)	6104	25 for \$10		
TEMPLATES FOR HAND-SCORING OF CBCL/2-3 PROFILES. (Same for both genders)	6204	\$7		
MANUAL FOR THE CBCL/2-3 AND PROFILE. 210 pp	6500	\$25		
COMPUTER PROGRAM FOR SCORING OF CBCL/2-3	6624	\$135		
CHILD BEHAVIOR CHECKLIST FOR AGES 4-18. Classic forms completed by parents	2004	25 for \$10		
PROFILES FOR HAND-SCORING OF CBCL/4-18. Boys	2104	25 for \$10		
Girls	2154	25 for \$10		
TEMPLATES FOR HAND-SCORING OF CBCL/4-18 PROFILES. (Same for both genders)	2204	\$7		
MACHINE-READABLE CBCL/4-18. Forms completed by parents & processed by fax or scanner	2305	25 for \$20		
MANUAL FOR THE CBCL/4-18 AND PROFILE. 288 pp	2500	\$25		
COMPUTER PROGRAM FOR SCORING OF CBCL/4-18	2626	\$220		
YOUTH SELF-REPORT FOR AGES 11-18. Classic forms completed by youths	5004	25 for \$10		
PROFILES FOR HAND-SCORING OF YSR. (Same for both genders)	5104	25 for \$10		
TEMPLATES FOR HAND-SCORING OF YSR PROFILES. (Same for both genders)	5204	\$7		
MACHINE-READABLE YSR. Forms completed by youths & processed by fax or scanner	5305	25 for \$20		
MANUAL FOR THE YSR AND PROFILE. 221 pp	5500	\$25		
COMPUTER PROGRAM FOR SCORING OF YSR	5626	\$220		
TEACHER'S REPORT FORM FOR AGES 5-18. Classic forms completed by teachers	3004	25 for \$10		
PROFILES FOR HAND-SCORING OF TRF. Boys	3104	25 for \$10		
Girls	3154	25 for \$10		
TEMPLATES FOR HAND-SCORING OF TRF PROFILES. (Same for both genders)	3204	\$7		
MACHINE-READABLE TRF. Forms completed by teachers & processed by fax or scanner	3305	25 for \$20		
MANUAL FOR THE TRF AND PROFILE. 214 pp	3500	\$25		
COMPUTER PROGRAM FOR SCORING OF TRF	3626	\$220		
EMPIRICALLY BASED TAXONOMY: How to Use CBCL/4-18, TRF, and YSR Syndromes and Profile Types. 212 pp . .	1500	\$25		
INTEGRATIVE GUIDE FOR THE CBCL/4-18, YSR, AND TRF PROFILES. 211 pp	1000	\$25		
Special price—5 books for the price of 3, plus \$10—save \$40: INTEGRATIVE GUIDE & EMPIRICALLY BASED TAXONOMY, plus CBCL/4-18, YSR, & TRF MANUALS	1501	\$85		
CROSS-INFORMANT PROGRAM FOR CBCL/4-18, YSR, TRF. With this program, you do not need CBCL/4-18, YSR, or TRF programs. Requires computer with 512K & hard disk	1624	\$295		
SCANNING SOFTWARE PACKAGE. Process CBCL/4-18, YSR, & TRF machine-readable forms with your fax or scanner. You then score the data via the CBCL/4-18, YSR, TRF, or Cross-Informant program. Requires 3rd party scanner software (see p. 2) & IBM-compatible computer with hard disk	1326	\$220		
CLIENT-ENTRY PROGRAM. Parents, youths, & teachers key enter their own responses to be scored by the CBCL/4-18, YSR, TRF, or Cross-Informant program. No need for CBCL/4-18, YSR, or TRF forms. Minimum computer specs: 386 chip; 4MB RAM; hard disk; color monitor. DOS version only	1426	\$220		

PLEASE TURN PAGE FOR ADDITIONAL ORDERING INFORMATION

COST OF GOODS _____

ORDER FORM (cont.)		Item	Price	Quantity
SEMISTRUCTURED CLINICAL INTERVIEW FOR CHILDREN & ADOLESCENTS. Protocol forms for use by interviewer		8004	25 for \$10	
COMBINED SCICA OBSERVATION & SELF-REPORT SCORING FORMS. Needed for scoring by hand or computer		8104	25 for \$10	
PROFILES FOR HAND-SCORING OF SCICA. (Same for both genders; no templates needed)		8134	25 for \$10	
MANUAL FOR THE SCICA. 228 pp		8504	\$25	
COMPUTER PROGRAM FOR SCORING OF SCICA		8624	\$135	
VHS VIDEO FOR PRACTICE SCORING OF SCICA INTERVIEWS. Circle if for use outside North America: PAL		8400	\$110	
DIRECT OBSERVATION FORM FOR AGES 5-14. Completed by observer		4004	25 for \$10	
PROFILES FOR HAND-SCORING OF DOF. (Same for both genders; no templates needed)		4114	25 for \$10	
COMPUTER PROGRAM FOR SCORING OF DOF		4624	\$135	
AUDIOCASSETTES. Development & Applications of Empirically Based Assessment by Dr. T.M. Achenbach ... 45 min.		1900	\$20	
School-Centered Applications of Empirically Based Assessment by Dr. Stephanie McConaughy ... 45 min.		1901	\$20	
Special price: Both 45-min. cassettes		1902	\$35	
1997 BIBLIOGRAPHY OF PUBLISHED STUDIES USING THE CBCL & RELATED MATERIALS. Printed version		7104	\$45	
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The use & interpretation of our materials require graduate training in standardized assessment procedures of at least the Master's degree level, plus thorough knowledge of the relevant Manuals & documentation. Administration of the SCICA additionally requires supervised experience in interviewing children. Eligibility to purchase our materials is determined on the basis of professional degree, licensing, relevant experience, & acceptance of the conditions indicated below. The user or supervisor named below agrees to adhere to the following conditions:

1. I will maintain the confidentiality of all assessment results.
2. I will avoid labeling individuals solely on the basis of scale scores.
3. I will strictly abide by copyright laws & will not reproduce or alter copyrighted materials.
4. I will employ & score assessment procedures precisely according to instructions.
5. I will release results only to authorized persons in conformity with professional standards for psychological assessment.

User's signature indicates compliance with the above conditions: Signature _____

Print name _____ Date _____

If you are a trainee & lack the equivalent of a Master's degree or appropriate license/certificate, please have your supervisor complete the following:

Supervisor's signature _____ Supervisor's name (print) _____

REGISTRATION OF QUALIFICATIONS: Check whether qualifications are for User ☐ or Supervisor ☐
Profession _____ Degree _____ License/certif. # _____ Jurisdiction _____

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store.
(Include *both* paid and unpaid jobs and chores.) ☐ None

Compared to others of the same age, how well does he/she carry them out?

Don't Know Below Average Average Above Average

a.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

V. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more
(Do *not* include brothers and sisters)

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do *not* include brothers and sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers and sisters?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Has no brothers or sisters
b. Get along with other kids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. Behave with his/her parents?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. Play and work alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

VII. 1. For ages 6 and older - performance in academic subjects: Not attending school because:

	Falling	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. History or Social Studies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Arithmetic or Math	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Science	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. <small>Other academic subjects - for example: computer course, foreign language, business. Do <i>not</i> include gym, shop, driver's ed., etc.</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Does your child receive special remedial services or attend a special class or special school? ☐ No ☐ Yes - kind of services, class or school:

3. Has your child repeated any grades? ☐ No ☐ Yes - grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes - please describe:

When did these problems start?

Have these problems ended? ☐ No ☐ Yes - when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes - please describe:

What concerns you most about your child?

Please describe the best things about your child:

7 1 1 1 5

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Please Print

Below is a list of items that describe children and youths. For each item that describes your child *now or within the past 6 months*, please fill in the bubble under 2 if the item is *very true or often true* of your child. Fill in the bubble under 1 if the item is *somewhat or sometimes true* of your child. If the item is *not true* of your child, fill in the bubble under 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2
☐ ☐ ☐

1. Acts too young for his/her age
 2. Allergy (describe):

0 1 2
☐ ☐ ☐

3. Argues a lot
 4. Asthma

0 1 2
☐ ☐ ☐

5. Behaves like opposite sex
 6. Bowel movements outside toilet

0 1 2
☐ ☐ ☐

7. Bragging, boasting
 8. Can't concentrate, can't pay attention for long

0 1 2
☐ ☐ ☐

9. Can't get his/her mind off certain thoughts; obsessions (describe):

0 1 2
☐ ☐ ☐

10. Can't sit still, restless, or hyperactive

0 1 2
☐ ☐ ☐

11. Clings to adults or too dependent
 12. Complaints of loneliness

0 1 2
☐ ☐ ☐

13. Confused or seems to be in a daze
 14. Cries a lot

0 1 2
☐ ☐ ☐

15. Cruel to animals
 16. Cruelty, bullying, oranness, other

0 1 2
☐ ☐ ☐

17. Day-dreams or gets lost in his/her thoughts
 18. Deliberately harms self or attempts suicide

0 1 2
☐ ☐ ☐

19. Demands a lot of attention
 20. Destroys his/her own things

0 1 2
☐ ☐ ☐

21. Destroys things belonging to his/her family or others

0 1 2
☐ ☐ ☐

22. Disobedient at home
 23. Disobedient at school
 24. Doesn't eat well

0 1 2
☐ ☐ ☐

25. Doesn't get along with other kids
 26. Doesn't seem to feel guilty after misbehaving

0 1 2
☐ ☐ ☐

27. Easily jealous
 28. Eats or drinks things that are not food - don't include sweets (describe):

0 1 2
☐ ☐ ☐

29. Fears certain animals, situations, or places, other than school (describe):

0 1 2
☐ ☐ ☐

30. Fears going to school

0 1 2
☐ ☐ ☐

31. Fears he/she might think or do something bad

0 1 2
☐ ☐ ☐

32. Feels he/she has to be perfect
 33. Feels or complains that no one loves him/her

0 1 2
☐ ☐ ☐

34. Feels others are out to get him/her
 35. Feels worthless or inferior

0 1 2
☐ ☐ ☐

36. Gets hurt a lot, accident-prone
 37. Gets in many fights

0 1 2
☐ ☐ ☐

38. Gets teased a lot
 39. Hangs around with others who get in trouble

0 1 2
☐ ☐ ☐

40. Hears sounds or voices that aren't there (describe):

0 1 2
☐ ☐ ☐

41. Impulsive or acts without thinking

0 1 2
☐ ☐ ☐

42. Would rather be alone than with others
 43. Lying or cheating

0 1 2
☐ ☐ ☐

44. Bites fingernails
 45. Nervous, highstrung, or tense

0 1 2
☐ ☐ ☐

46. Nervous movements or twitching (describe):

0 1 2
☐ ☐ ☐

47. Nightmares

0 1 2
☐ ☐ ☐

48. Not liked by other kids
 49. Constipated, doesn't move bowels

0 1 2
☐ ☐ ☐

50. Too fearful or anxious
 51. Feels dizzy

0 1 2
☐ ☐ ☐

52. Feels too guilty
 53. Overeating

0 1 2
☐ ☐ ☐

54. Overtired
 55. Overweight

0 1 2
☐ ☐ ☐

56. Physical problems *without known medical cause*:

- a. Aches or pains (*not* stomach or headaches)
 b. Headaches
 c. Nausea, feels sick
 d. Problems with eyes (*not* if corrected by glasses) (describe):

0 1 2
☐ ☐ ☐

- e. Rashes or other skin problems
 f. Stomachaches or cramps
 g. Vomiting, throwing up
 h. Other (describe):

0 1 2
☐ ☐ ☐

57. Physically attacks people

7 1 1 1 5

Please see other side

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Please Print

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2
58. Picks nose, skin, or other parts of body (describe):

0 1 2
59. Plays with own sex parts in public
60. Plays with own sex parts too much

0 1 2
61. Poor school work
62. Poorly coordinated or clumsy

0 1 2
63. Prefers being with older kids
64. Prefers being with younger kids

0 1 2
65. Refuses to talk
66. Repeats certain acts over and over; compulsions (describe):

0 1 2
67. Runs away from home
68. Screams a lot

0 1 2
69. Secretive, keeps things to self
70. Sees things that aren't there (describe):

0 1 2
71. Self-conscious or easily embarrassed
72. Sets fires

0 1 2
73. Sexual problems (describe):

0 1 2
74. Showing off or clowning

0 1 2
75. Shy or timid
76. Sleeps less than most kids

0 1 2
77. Sleeps more than most kids during day and/or night (describe):

0 1 2
78. Smears or plays with bowel movements

0 1 2
79. Speech problem (describe):

0 1 2
80. Stares blankly

0 1 2
81. Steals at home
82. Steals outside the home

0 1 2
83. Stores up things he/she doesn't need (describe):

0 1 2
84. Strange behavior (describe):

0 1 2
85. Strange ideas (describe):

0 1 2
86. Stubborn, sullen, or irritable

0 1 2
87. Sudden changes in mood or feelings
88. Sulks a lot

0 1 2
89. Suspicious
90. Swearing or obscene language

0 1 2
91. Talks about killing self
92. Talks or walks in sleep (describe):

0 1 2
93. Talks too much
94. Teases a lot

0 1 2
95. Temper tantrums or hot temper
96. Thinks about sex too much

0 1 2
97. Threatens people
98. Thumb-sucking

0 1 2
99. Too concerned with neatness or cleanliness
100. Trouble sleeping (describe):

0 1 2
101. Truancy, skips school
102. Underactive, slow moving, or lacks energy

0 1 2
103. Unhappy, sad, or depressed
104. Unusually loud

0 1 2
105. Uses alcohol or drugs for nonmedical purposes (describe):

0 1 2
106. Vandalism

0 1 2
107. Wets self during the day
108. Wets the bed

0 1 2
109. Whining
110. Wishes to be of opposite sex

0 1 2
111. Withdrawn, doesn't get involved with others
112. Worries

113. Please write in any problems your child has that were not listed above:

0 1 2

7 1 1 1 5

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YOUTH SELF-REPORT FOR AGES 11-18

For office use only
ID # _____

YOUR NAME _____			PARENTS' USUAL TYPE OF WORK, even if not working now (Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.) FATHER'S TYPE OF WORK: _____ MOTHER'S TYPE OF WORK: _____		
YOUR SEX <input type="checkbox"/> Boy <input type="checkbox"/> Girl	YOUR AGE _____	ETHNIC GROUP OR RACE _____	Please fill out this form to reflect <i>your</i> views, even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on pages 2 and 4.		
TODAY'S DATE Mo. _____ Date _____ Yr. _____	YOUR BIRTHDATE Mo. _____ Date _____ Yr. _____				
GRADE IN SCHOOL _____ NOT ATTENDING SCHOOL <input type="checkbox"/>	IF YOU ARE WORKING, STATE TYPE OF WORK _____				

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc. <input type="checkbox"/> None a. _____ b. _____ c. _____	Compared to others of your age, about how much time do you spend in each?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Less Than Average</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">More Than Average</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Less Than Average	Average	More Than Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Compared to others of your age, how well do you do each one?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Below Average</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">Above Average</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Below Average	Average	Above Average	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																										
II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, autos, crafts, etc. (Do not include listening to radio or TV.) <input type="checkbox"/> None a. _____ b. _____ c. _____	Compared to others of your age, about how much time do you spend in each?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Less Than Average</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">More Than Average</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Less Than Average	Average	More Than Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Compared to others of your age, how well do you do each one?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Below Average</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">Above Average</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Below Average	Average	Above Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																										
III. Please list any organizations, clubs, teams or groups you belong to. <input type="checkbox"/> None a. _____ b. _____ c. _____	Compared to others of your age, how active are you in each?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Less Active</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">More Active</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Less Active	Average	More Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
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IV. Please list any jobs or chores you have. For example: Paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.) <input type="checkbox"/> None a. _____ b. _____ c. _____	Compared to others of your age, how well do you carry them out?	<table style="width: 100%; text-align: center;"> <tr> <th style="width: 33%;">Below Average</th> <th style="width: 33%;">Average</th> <th style="width: 33%;">Above Average</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Below Average	Average	Above Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																										

- V. 1. About how many close friends do you have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more
(Do not include brothers & sisters)
2. About how many times a week do you do things with any friends outside of regular school hours?
(Do not include brothers & sisters) ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	About the same	Better	
a. Get along with your brothers & sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I have no brothers or sisters
b. Get along with other kids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Get along with your parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Do things by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

VII. Performance in academic subjects. ☐ I do not go to school because _____

	Failing	Below Average	Average	Above Average
a. English or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other academic subjects — for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc.

Do you have any illness, physical disability, or handicap? ☐ No ☐ Yes — please describe

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

Below is a list of items that describe kids. For each item that describes you **now** or **within the past 6 months**, please circle the 2 if the item is **very true or often true** of you. Circle the 1 if the item is **somewhat or sometimes true** of you. If the item is **not true** of you, circle the 0.

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1. I act too young for my age	0	1	2	40. I hear sounds or voices that other people think aren't there (describe):
0	1	2	2. I have an allergy (describe):				
0	1	2	3. I argue a lot	0	1	2	41. I act without stopping to think
0	1	2	4. I have asthma	0	1	2	42. I would rather be alone than with others
0	1	2	5. I act like the opposite sex	0	1	2	43. I lie or cheat
0	1	2	6. I like animals	0	1	2	44. I bite my fingernails
0	1	2	7. I brag	0	1	2	45. I am nervous or tense
0	1	2	8. I have trouble concentrating or paying attention	0	1	2	46. Parts of my body twitch or make nervous movements (describe):
0	1	2	9. I can't get my mind off certain thoughts (describe):				
0	1	2	10. I have trouble sitting still	0	1	2	47. I have nightmares
0	1	2	11. I'm too dependent on adults	0	1	2	48. I am not liked by other kids
0	1	2	12. I feel lonely	0	1	2	49. I can do certain things better than most kids
0	1	2	13. I feel confused or in a fog	0	1	2	50. I am too fearful or anxious
0	1	2	14. I cry a lot	0	1	2	51. I feel dizzy
0	1	2	15. I am pretty honest	0	1	2	52. I feel too guilty
0	1	2	16. I am mean to others	0	1	2	53. I eat too much
0	1	2	17. I daydream a lot	0	1	2	54. I feel overtired
0	1	2	18. I deliberately try to hurt or kill myself	0	1	2	55. I am overweight
0	1	2	19. I try to get a lot of attention	0	1	2	56. Physical problems without known medical cause:
0	1	2	20. I destroy my own things	0	1	2	a. Aches or pains (<i>not</i> headaches)
0	1	2	21. I destroy things belonging to others	0	1	2	b. Headaches
0	1	2	22. I disobey my parents	0	1	2	c. Nausea, feel sick
0	1	2	23. I disobey at school	0	1	2	d. Problems with eyes (describe):
0	1	2	24. I don't eat as well as I should				
0	1	2	25. I don't get along with other kids				
0	1	2	26. I don't feel guilty after doing something I shouldn't				
0	1	2	27. I am jealous of others	0	1	2	e. Rashes or other skin problems
0	1	2	28. I am willing to help others when they need help	0	1	2	f. Stomachaches or cramps
0	1	2	29. I am afraid of certain animals, situations, or places, other than school (describe):	0	1	2	g. Vomiting, throwing up
				0	1	2	h. Other (describe):
0	1	2	30. I am afraid of going to school	0	1	2	57. I physically attack people
0	1	2	31. I am afraid I might think or do something bad	0	1	2	58. I pick my skin or other parts of my body (describe):
0	1	2	32. I feel that I have to be perfect				
0	1	2	33. I feel that no one loves me				
0	1	2	34. I feel that others are out to get me				
0	1	2	35. I feel worthless or inferior	0	1	2	59. I can be pretty friendly
0	1	2	36. I accidentally get hurt a lot	0	1	2	60. I like to try new things
0	1	2	37. I get in many fights	0	1	2	61. My school work is poor
0	1	2	38. I get teased a lot	0	1	2	62. I am poorly coordinated or clumsy
0	1	2	39. I hang around with kids who get in trouble	0	1	2	63. I would rather be with older kids than with kids my own age

0 = Not True

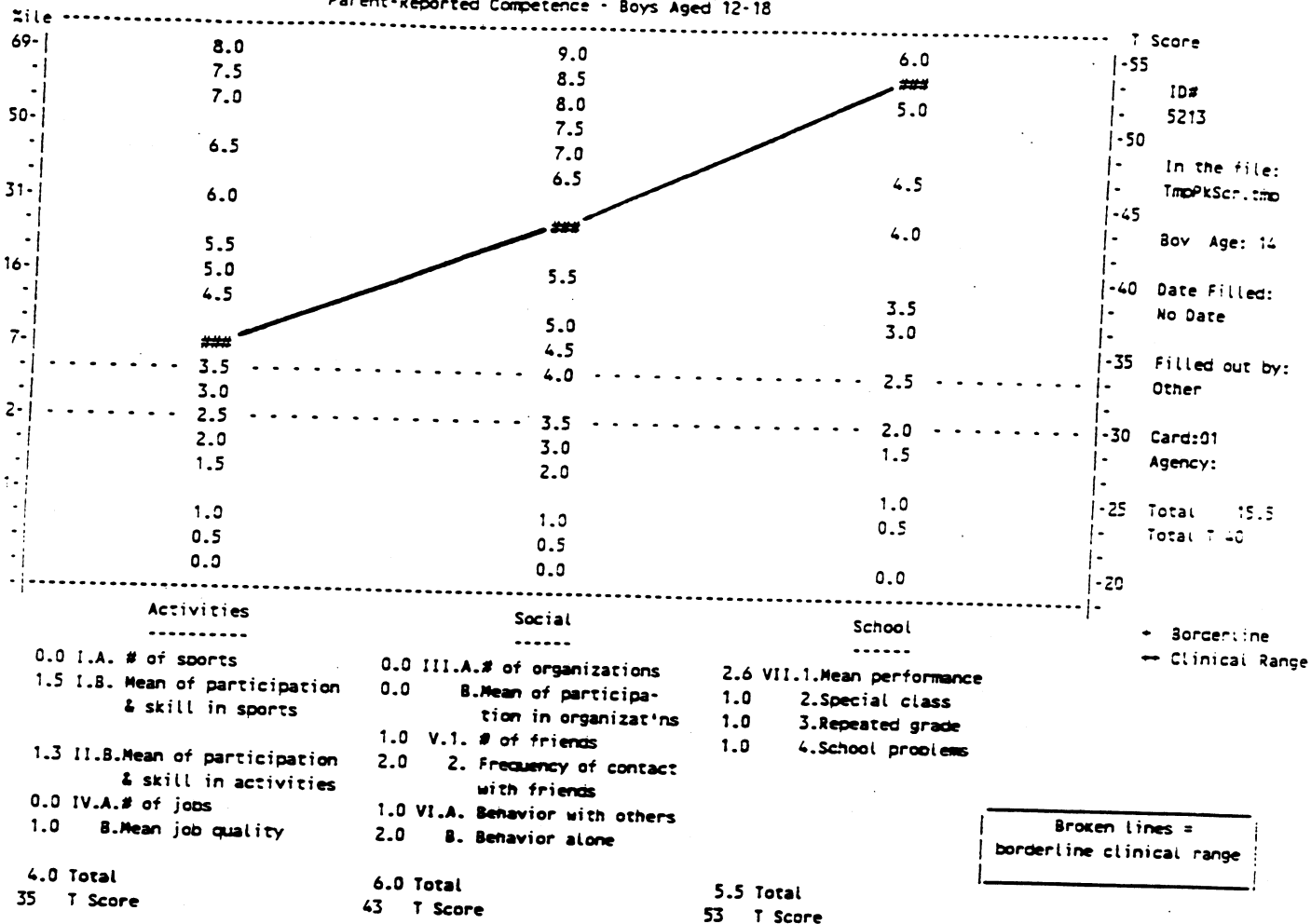
1 = Somewhat or Sometimes True

2 = Very True or Often True

0	1	2	64.	I would rather be with younger kids than with kids my own age	0	1	2	85.	I have thoughts that other people would think are strange (describe): _____
0	1	2	65.	I refuse to talk					_____
0	1	2	66.	I repeat certain actions over and over (describe): _____					_____
				_____					_____
0	1	2	67.	I run away from home	0	1	2	86.	I am stubborn
0	1	2	68.	I scream a lot	0	1	2	87.	My moods or feelings change suddenly
0	1	2	69.	I am secretive or keep things to myself	0	1	2	88.	I enjoy being with other people
0	1	2	70.	I see things that other people think aren't there (describe): _____	0	1	2	89.	I am suspicious
				_____	0	1	2	90.	I swear or use dirty language
				_____	0	1	2	91.	I think about killing myself
0	1	2	71.	I am self-conscious or easily embarrassed	0	1	2	92.	I like to make others laugh
0	1	2	72.	I set fires	0	1	2	93.	I talk too much
0	1	2	73.	I can work well with my hands	0	1	2	94.	I tease others a lot
0	1	2	74.	I show off or clown	0	1	2	95.	I have a hot temper
0	1	2	75.	I am shy	0	1	2	96.	I think about sex too much
0	1	2	76.	I sleep less than most kids	0	1	2	97.	I threaten to hurt people
0	1	2	77.	I sleep more than most kids during day and/or night (describe): _____	0	1	2	98.	I like to help others
				_____	0	1	2	99.	I am too concerned about being neat or clean
				_____	0	1	2	100.	I have trouble sleeping (describe): _____
				_____					_____
0	1	2	78.	I have a good imagination					_____
0	1	2	79.	I have a speech problem (describe): _____	0	1	2	101.	I cut classes or skip school
				_____	0	1	2	102.	I don't have much energy
				_____	0	1	2	103.	I am unhappy, sad, or depressed
				_____	0	1	2	104.	I am louder than other kids
0	1	2	80.	I stand up for my rights	0	1	2	105.	I use alcohol or drugs for nonmedical purposes (describe): _____
0	1	2	81.	I steal at home					_____
0	1	2	82.	I steal from places other than home					_____
0	1	2	83.	I store up things I don't need (describe): _____					_____
				_____					_____
0	1	2	84.	I do things other people think are strange (describe): _____	0	1	2	106.	I try to be fair to others
				_____	0	1	2	107.	I enjoy a good joke
				_____	0	1	2	108.	I like to take life easy
				_____	0	1	2	109.	I try to help other people when I can
				_____	0	1	2	110.	I wish I were of the opposite sex
				_____	0	1	2	111.	I keep from getting involved with others
				_____	0	1	2	112.	I worry a lot

Please write down anything else that describes your feelings, behavior, or interests

Child Behavior Checklist Profile
Parent-Reported Competence - Boys Aged 12-18



= plotted score

Total Score for each scale is rounded to nearest 0.5.
Indicates the score was not computed due to missing data.
On Activities and Social Scales, if one item is missing, the mean of the other items is substituted.

Broken lines =
borderline clinical range

Not scored on competence scales
2.0 II.A. # of other activities

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Burlington, VT 05401-3456

Internalizing				CBCL Profile - Boys 12-18				Externalizing		T Score	
C	-	17	27					25	39	-	ID# 9999
l	-	17	26	15	13	21		24	38	-	IN:BOY1.CBC
i	-		16			20			37	-	95 Boy AGE: 14
n	-	16	24	14	12			22	36	-	DATE FILLED:
i	-	15	23		11	19		21	34	-	No Date
c	-			13						-	90 BY: Missing
a	-	14	22	WARNING: Data are not key-verified				20	33	-	CARDS 02,03
l	-	12	21	12		17		19	31	-	AGENCY
-	-	13	20		9			18		-	
R	-	11	19	11				17	29	-	
a	-	12	18		8	15		16	28	-	# ITEMS 31
n	-			10						-	80 TOTSCORE 36
g	-	11	16		7	14		14	26	-	TOT T +60
e	-	10	15	9	6			13	25	-	INTERNAL 4
-	-	7				13		24		-	75 INT T 48
%ILE-	-	9	14	8	5	12		23		-	EXTERNAL 22
-	-	6	13				###	22		-	EXT T ++66
98	-	-8-	5	-12-	-7-	4	-11-	10-	21-	-	70 ++ Clinical
-	-	7	4	10	6	3	10	7	18	-	+ Borderline
-	-				5				17	-	
93	-	6	9			9		6	16	-	65 OTHER PROBS
-	-		3	8	4	2	8	5	15	-	0 5. ActOppSex
-	-	5	7				7	4	14	-	- 6. BM Out
84	-		6						13	-	60 0 15.CruelAnim
-	-	4	2	5	###	6		3	11	-	2 18.HarmSelf
-	-		4			5			###	-	0 24.NotEat
69	-	3		2		4				-	55 0 28.EatNonFood
-	-		1	###				2	7	-	0 29.Fears
-	-								6	-	0 30.FearSchool
50	-	###	###	0-2	0-1	###	0-2	0-1	0-5	-	50 0 36.GetHurt
		I	II	III	IV	V	VI	VII	VIII		0 44.BiteNail
		WITHDRAWN	SOMATIC COMPLAINTS	ANXIOUS/ DEPRESSED	SOCIAL PROBLEMS	THOUGHT PROBLEMS	ATTENTION PROBLEMS	DELINQUENT BEHAVIOR	AGGRESSIVE BEHAVIOR		1 47.Nightmares
0 42.	Rather BeAlone	0 51. Dizzy	1 12.Lonely	2 1. Acts Young	0 9. Mind Off	2 1. Acts Young	0 26.NoGuilt	- 3. Argues	0 49.Constipate		0 53.Overeat
0 65.	Won't Talk	0 56a.Aches	0 31.FearDoBad	1 11.Clings	0 40.Hears Things	0 8. Concen- trate	0 43.LieCheat	0 16.Mean	0 58.PickSkin		0 59.SexPrtsP
1 69.	Secret-ive	0 56b.Head-aches	0 33.Unloved	0 25.NotGet Along	0 66.Repeats Acts	1 10.Sit Still	0 67.RunAway	1 20.DestOwn	0 60.SexPrtsM		0 73.SexProbs
0 75.	Shy	- 56d.Eye	0 35.Worthless	0 48.Not Liked	0 70.Sees Things	0 13.Confuse	1 72.SetFires	0 21.DestOthr	0 73.SexProbs		1 76.SleepLess
0 80.	Stares	0 56e.Skin	0 45.Nervous	0 55.Over- Weight*	0 80.Stares* Behav	0 17.Day- dream	1 81.StealHome	0 23.DisbSchl	0 77.SleepMore		0 78.SmeatBM
0 88.	Sulks	0 56f.Stomach	0 50.Fearful	0 62.Clumsy	0 84.Strange Ideas	0 41.Impulsv	0 96.ThinkSex*	0 37.Fights	0 83.StoresUp		1 91.TalkSuicid
0 102.	Under- active	0 56g.Vomit	0 52.Guilty	0 64.Prefers Young	0 85.Strange Ideas	0 46.Twitch*	1 105.AlcDrugs	1 68.Screams	1 92.SleepWalk		0 98.ThumbSuck
0 103.	Sad	50 T SCORE	0 89.Suspicious	3 TOTAL	0 TOTAL	0 62.Clumsy	1 106.Vandal*	1 74.ShowOff	1 99.TooNeat		0 100.SleepProb
0 111.	With- drawn	41 CLIN T	0 103.Sad	59 T SCORE	40 CLIN T	0 80.Stares	12 TOTAL	1 86.Stubborn	0 107.WetsSelf		0 108.WetsBed
1 TOTAL			0 112.Worries	44 CLIN T		3 TOTAL	74 T SCORE	1 87.MoodChng	0 109.Whining		0 110.WshOpSex
50 T SCORE			3 TOTAL			51 T SCORE	61 CLIN T	0 93.TalkMuch	- 113.OtherProb		
35 CLIN T			53 T SCORE			34 CLIN T		1 94.Teases			
			37 CLIN T					1 95.Temper			
								0 97.Threaten			
								0 104.Loud			
								10 TOTAL			
								57 T SCORE			
								42 CLIN T			

*Items not on Cross-Informant Construct

Not in Total Problem Score
2 2.Allergy 2 4.Asthma

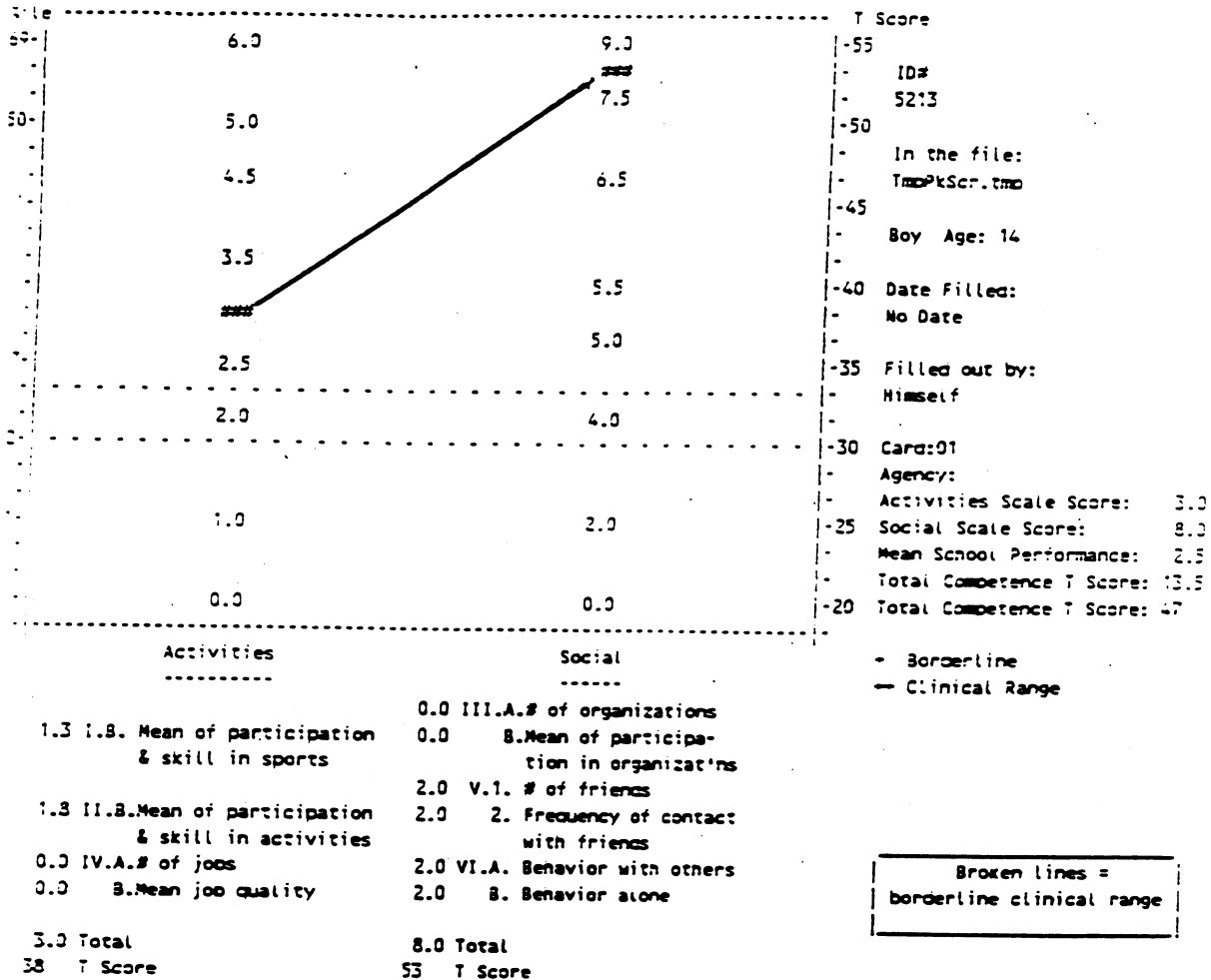
Profile Type: WTHDR SOMAT SOCIAL DEL-AGG W-A/D-Agg Soc-Att Delinq
ICC: -.160 -.138 -.481 .313 -.480 -.493 .672**

** Significant ICC with profile type

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Internalizing				YSR Profile - Boys 11-18				Externalizing		T Score	
C -		31						21	37	ID# 9999	
1 -	###	30		15		17		36		IN:BOY1.YSR	
i -					13			20	35	-95 Boy AGE: 14	
n -	13	16	28	14				19	###	DATE FILLED:	
i -		15	27			16			33	No Date	
c -					12			18		-90 CARD 02,03	
a -	12	14	26	13				17	31	AGENCY	
l -			25			###			30		
-		13	24	12	11			16		-85	
R -			23			14		15	29		
a -	11	12	22	11					27	# ITEMS 66	
n -					10			14		-80 TOTSCORE 127	
g -		11	###	10		13		13	26	TOT T ++83	
e -	10	10	19						25	INTERNAL 43	
-					9			12	24	-75 INT T ++84	
%ILE-		9	18	9		12		11	23	EXTERNAL 44	
-			17						22	EXT T ++84	
98 -	-9-	8	-16	###	8	-11		###	21	-70 ++ Clinical	
-	###	7	13	7	7	10		8	18	+ Borderline	
-											
93 -		6	12		6			7	17	-65	
-	7		11	6		9			16		
-	6	5	10	5	5			6	14	OTHER PROBS	
84 -			9			8				-60 1 5. ActOppSex\$	
-		4	8	4	4			5	13	2 22.Disobey	
-	5	3	7	4		7			12	0 24.NotEat	
69 -				3	3			4	11	-55 0 29.Fears	
-	4		6			6			10	2 30.FearSchool	
-		2	5			5		3	9	2 36.GetHurt	
50 -	0-3	0-1	0-4	0-2	###	0-4		0-2	0-8	-50 2 44.BiteNail	
WITHDRAWN				V				VII		VIII	
SOMATIC COMPLAINTS				THOUGHT PROBLEMS				DELINQUENT BEHAVIOR		AGGRESSIVE BEHAVIOR	
2 42.Rather BeAlone	2 51. Dizzy	0 12.Lonely\$	0 1. Acts Young	0 9. Mind Off	0 1. Acts Young	0 26.NoGuilt	1 3. Argues	2 39.BadCompan	2 7. Brags	0 56h.OtherPhys	2 46.Twitch
2 65.Won't Talk	2 56a.Aches	0 18.HarmsSlf*\$	0 11.Clings	2 40.Hears	2 8. Concen- trate	2 39.BadCompan	2 7. Brags	0 43.LieCheat	2 16.Mean	0 58.PickSkin	2 53.EatTooMuch
0 69.Secretive	2 56b.Head- aches	0 32.Perfect	2 25.NotGet Along	0 66.Repeats	2 10.Sit Still	0 63.PrefOlder	2 19.DemAttn	0 67.RunAway	2 20.DestOwn\$	2 77.SleepMore	0 76.SleepLess
0 75.Shy	1 56c.Nausea	2 33.Unloved\$	0 38.Teased	0 70.Sees	2 13.Con- fused\$	0 72.SetFires	2 21.DestOthr	0 81.StealHome	2 23.DisobSchl	2 99.TooNeat	2 79.SpeechProb\$
0 102.Underactive	2 56d.Eye	2 34.OutToGet	2 48.Not Liked	0 83.Store Up*	2 17.Day- dream	0 82.StealOut	2 27.Jealous\$	2 90.Swears	0 37.Fights	0 100.SleepProb	2 96.ThinkSex
2 103.Sad	2 56e.Skin	2 35.Worthless\$	2 62.Clumsy	0 84.Strange Behav	1 41.Impul- sive	2 101.Truant	1 57.Attacks\$	2 105.AlcDrugs	2 68.Screams	0 110.WishOpSex\$	2 99.TooNeat
2 111.Withdrawn	2 56f.Stomach	2 45.Nervous	2 64.Prefers Young	0 85.Strange Ideas	2 61.Poor School	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
8 TOTAL	17 TOTAL	2 52.Guilty	2 111.Withdrawn*	0 85.Strange Ideas	2 61.Poor School	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
68 T SCORE	97 T SCORE	2 52.Guilty	2 111.Withdrawn*	0 85.Strange Ideas	2 61.Poor School	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
61 CLIN T	89 CLIN T	2 89.Suspicious	8 TOTAL	2 TOTAL	2 61.Poor School	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
		2 91.Think Suicid*\$	70 T SCORE	2 TOTAL	2 61.Poor School	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
		2 103.Sad	62 CLIN T	50 T SCORE	2 62.Clumsy	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
		2 112.Worries	43 CLIN T	15 TOTAL	87 T SCORE	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
		20 TOTAL	78 T SCORE	Not in Total Problem Score	73 CLIN T	2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
		68 CLIN T	0 2.Allergy	2 4.Asthma		2 105.AlcDrugs	2 68.Screams	2 74.ShowOff			2 99.TooNeat
*Items not on Cross-Informant Construct											
No ICCs are significant											
Profile Type: WTHDR SOMAT SOCIAL DEL-AGG YSR Soc Att-Del-Agg											
ICC: -.540 -.415 -.244 -.388 -.492 -.106											
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Youth Self-Report Profile
Self-Reported Competence - Boys Aged 11-18



*** = plotted score

Total Score for each scale is rounded to nearest 0.5.

*** Indicates the score was not computed due to missing data.
On Social Scale, if one item is missing,
the mean of the other items is substituted.

Broken lines =
borderline clinical range

Not scored on competence scales:
1.0 I.A. # of sports
2.0 II.A. # of other activities

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SECTION 6 - CAFAS

General Information

The Child and Adolescent Functional Assessment Scale (CAFAS) was developed, validated, and copyrighted by Kay Hodges, Ph.D., at the University of Michigan at Ann Arbor. The CAFAS, which is completed by a clinician or other appropriately trained mental health worker, is intended to be administered to “school age” children. Dr. Hodges determines this to be roughly from age 7 through 17. For the purpose of performance outcomes reporting, the CAFAS should be completed for Seriously Emotionally Disturbed (SED) children and adolescent clients age 7 through 18.

Designed to assess the extent to which a child or adolescent is experiencing functional impairment(s), the CAFAS generates eight scales that relate to how the child is functioning in a variety of domains. These eight scales, which are described later in this section, include: 1) Role Performance - Home; 2) Role Performance - School/Work; 3) Role Performance - Community; 4) Behavior Toward Others; 5) Moods and Emotions; 6) Moods/Self Harmful Behavior; 7) Substance Abuse; and 8) Thinking. Scales 1, 2, and 3 are collapsed into a single “Role Performance” scale which is simply the highest score from scale 1, 2, or 3. Similarly, scales 5 and 6 are collapsed into a single “Moods/Self-Harm” scale which is the highest score from scales 5 and 6. A total score is generated from the CAFAS scales which can be easily interpreted using guidelines supplied by Dr. Hodges. Scoring the CAFAS will be described in greater detail later in this section.

The CAFAS takes about 10 to 15 minutes for the clinician to complete. It was designed to use common language that parents would understand and find useful. Dr. Hodges’ goal was to develop an instrument that would not simply be another form for a clinician to fill out. On the contrary, her goal was to create a tool that the clinician would find useful, efficient, and effective in collecting information that can be of significant help in treatment planning and service provision.

Development Approach

The CAFAS was modeled after the North Carolina Functional Assessment Scale (NCFAS), a measure developed by the North Carolina Department of Human Resources (1989). The first author made extensive modifications to the items and scales of the NCFAS to render them more appropriate for children, and subsequently sought input from 40 experts on three separate occasions after each revision of the developing instrument. Colleagues were selected who could provide input from a variety of perspectives, including child psychopathology, normal development, and the special needs of Hispanic and Afro-American children. Suggestions were also obtained from spokespersons for parent advocate groups.

Validity and Reliability

Note: Refer to Section 3 for details on validity and reliability methodologies.

Data on the psychometric properties of the CAFAS have been produced from two large evaluations: the Ft. Bragg Evaluation Project (FBEP; Hodges & Wong, 1996; 1997) and the national evaluation being conducted of the demonstration grants funded by the Center for Mental Health Services (CMHS; Hodges, Doucette-Gates & Liao, 1996). The FBEP youth were referred for mental health services, and the youth in the CMHS evaluation are seriously emotionally disturbed (SED) or at-risk for SED.

Validity pertains to the accuracy with which a procedure measures what it is supposed to measure and the extent to which confidence may be placed in inferences made on the basis of instrument scores or other data. Evidence supports the validity of the CAFAS scores for content, contrast group, and predictive validity. Content validity refers to whether an instrument's content includes items that are related to the area being assessed. The items on the CAFAS have high content validity; items refer to specific behaviors in specified domains of functioning.

Contrast group validity, which is synonymous to concurrent criterion-related validity, refers to how the instrument effectively discriminates between groups on some current trait. Contrast group validity of the CAFAS has been demonstrated in both evaluations. Inpatients scored as more impaired than youth in alternative care (e.g., home-based services, day treatment), who in turn scored as more impaired than youth in outpatient care (Hodges & Wong, 1996).

Predictive validity refers to the ability to make predictive decisions based on the score on an instrument. Predictive validity was demonstrated in the Ft. Bragg Evaluation Project (FBEP) study (Hodges & Wong, 1997). The CAFAS score at intake was found to be related to services received over the subsequent year. Higher impairment, as measured by the CAFAS, was significantly related to more restrictive care, higher cost of services, more bed days, and more days of service. Furthermore, the predictive power of the CAFAS at intake was compared to a variety of common diagnoses for children and to other commonly used assessment instruments. The CAFAS at intake was the strongest predictor of costs and services at both 6 and 12 months.

Reliability refers to agreement between repeated assessments of phenomena when the phenomena themselves remain constant. The degree of internal consistency, inter-interviewer reliability and test-retest reliability were analyzed for the CAFAS. Internal consistency refers to degree to which there is inter-item correlations within the instrument. Inter-interviewer reliability refers to the degree to which different interviewers obtain similar results. Test-retest reliability refers to the degree to which the same informants provide the same scores over periods when

the subjects' behavior is not expected to change. Internal consistency has been demonstrated in both evaluations.

High inter-rater reliability has been reported for the CAFAS across different sites and with both lay and clinician raters (Hodges & Wong, 1996). The test-retest reliability correlations for the CAFAS are summarized below in Table 6-1. Good test-retest reliability of CAFAS scale scores was demonstrated by the mean test-retest correlations obtained from two sets of interviews conducted within 14 days of one another.

TABLE 6-1: CAFAS Test-Retest Reliability Correlations

<i>CAFAS Scale</i>	<i>Pearson Correlation: Total Sample</i>	<i>Pearson Correlation: Referred Sample</i>
Total Child Score	.95	.88
Role Performance	.84	.69
Behavior Toward Self and Others	.82	.68
Moods/Emotions	.91	.85
Thinking	.89	.87
Caregiver: Family/Social Support	.79	.75

Scales and Definitions

Following are descriptions and definitions that are important to administering and interpreting CAFAS scores.

TABLE 6-2: CAFAS Scales

Scale Name	Description
Role Performance	<ul style="list-style-type: none"> The extent to which a given child or adolescent client is experiencing functional deficiencies while fulfilling the roles that are most relevant to his or her place in society. The Role Performance Scale is comprised of three subscales which include: <ul style="list-style-type: none"> Role Performance - School/Work Role Performance - Home Role Performance - Community
Behavior Toward Others	This scale evaluates the extent to which the child or adolescent client's behavior toward others (e.g., adults, peers, etc.) is inappropriate and unacceptable. This scale also evaluates risk taking behaviors as well as those behaviors that indicate excessive impulsiveness.
Moods/Self-Harm	To the extent that a child or adolescent client's moods and emotions are poorly modulated and to the extent that the youth is exhibiting behaviors that could indicate a tendency to engage in self-harmful behaviors, the score on this scale will be high. This scale is

	<p>comprised of two subscales which include:</p> <ul style="list-style-type: none">• Moods/Emotions• Self-Harmful Behavior
--	---

Scale Name	Description
Substance Use	This scale evaluates the extent to which the youth's use of either synthetic or natural substances is resulting in behavior which is maladaptive, inappropriate, or disruptive to normal functioning.
Thinking	The Thinking scale evaluates the extent to which the child or adolescent client appears incapable of, and actually fails to use, well oriented and rational thought processes.

There are two additional scales which are included on the CAFAS which relate to the youth's family. These scales are intended to evaluate the extent to which the family is capable of and actually providing sufficient material and social support. These scales, while potentially useful to clinicians, are not required for the purpose of performance outcomes reporting to the State Department of Mental Health and therefore will not be reported.

Clinical Utility

The primary clinical utility of the CAFAS is that it provides a structured, valid, and reliable way for evaluating a child or adolescent clients' behaviors and evaluating the extent to which those behaviors are affecting the child's life functioning. Additionally, using the CAFAS profile which is generated as a result of completing the instrument, provides the clinician with a graphical presentation of the child's levels of functioning in a variety of domains. This information can be used with and compared to the profiles generated by the administration of the Child Behavior Check List (CBCL) and the Youth Self Report (YSR) in order to obtain a more complete picture of how the child is functioning.

The CAFAS, because it uses ordinary language that is understood by most people, can be an effective tool for a clinician to use when describing the child's problems and how they are affecting his or her functioning.

The CAFAS can be used to track changes in levels of functioning over time. More specifically, if the clinician has marked all items within the selected level of severity in a domain (e.g., Role Performance - School), then the clinician will be able to track more subtle improvements in the child's problems—even if the child has not actually changed severity categories. Additionally, the CAFAS can be used to provide structure to the goal setting process by identifying specific areas to target for improvement.

Developing Inter-Rater Reliability

Demonstration exercises are provided at the end of this section for clinicians to develop a level of familiarity with the CAFAS. In addition, the State Mental Health Department is recommending to County Mental Health management that all clinicians who will administer the CAFAS also complete a series of ten reliability vignettes for which rating takes approximately

3-4 hours to develop inter-rater reliability. This means that all raters would rate any given case the same way. Details on how to train staff are contained in the manuals listed in “Sources of Further Information” on page 6-7.

NOTE: It is critical that clinicians be fully trained and can demonstrate inter-rater reliability. Only if ratings are reliable can true outcome effects be consistently detected. The developer of the CAFAS recommends that each county document that each individual who will complete the CAFAS has successfully demonstrated inter-rater reliability through completing a series of reliability vignettes.

Administration Procedures

Who can administer the CAFAS?

The CAFAS is most effective if it is completed by the clinician. This is because it is designed to facilitate the clinician’s careful consideration of specific problems that relate to the child’s behavior and functional level. However, the State Department of Mental Health is not mandating that the clinician personally complete the CAFAS. However, if a mental health worker, other than the primary clinician, is assigned the task of completing the CAFAS, that person must be appropriately training on the administration and use of the instrument. This training should include: 1) an overview of the CAFAS instrument; 2) practical experience in interpreting child behaviors using the CAFAS; and 3) completed a process to assure that the staff member is able to complete the CAFAS in a manner that demonstrates inter-rater reliability.

Staff, when appropriately training, considered appropriate for administering the CAFAS include but may not be limited to:

- Clinician
- Paraprofessionals who are overseen by licensed or licensed waiver staff
- Licensed Practitioner of the Healing Arts (MD, LCSW, MFCC, Licensed Psychologist, RN)
- Waivered Staff (IMFCC, ACSW)
- Psychologist Interns

Instructions

1) Do not write on the CAFAS rating forms; these are to be reused for multiple cases. Use the CAFAS Profile form to record the client’s functioning on each scale. The clinician should consider all information available about the youth (from direct interview, case records, or

previous therapist, etc.) to rate the impairment level for each domain. Table 6-3 summarizes the CAFAS 4-level rating system. Higher scores indicate more severe dysfunction.

TABLE 6-3: CAFAS 4-Level Rating System

Rating	Degree of Dysfunction or Impairment
30	Severe Impairment (severe disruption or incapacitation)
20	Moderate Impairment (occasional major disruption or frequent disruptions)
10	Mild Impairment (significant problems and/or distress)
0	Minimal or No Impairment (no disruption of functioning)

- 2) The CAFAS is designed to assess the most severe level of impairment. Always begin the assessment of each scale in the far left “Severe Impairment” column. Circle all applicable item numbers of that column that describe the youth’s functioning. If any items of this column are circled, fill in the bubble for a score of 30 and then move on to the following scale on the next page.
- 3) If no items apply in the “Severe Impairment” column, go on to the “Moderate Impairment” column. If no items apply in the “Moderate Impairment” column, proceed to the “Mild Impairment” column, and so on. If the youth is described by any of the items in a level, then that level of impairment will apply to the client. **ALWAYS START AT THE SEVERE LEVEL AND PROGRESSIVELY PROCEED TO THE MINIMAL/NO IMPAIRMENT LEVEL, STOPPING AT THE LEVEL AT WHICH THE YOUTH IS DESCRIBED BY ANY ONE OF THE ITEMS IN THAT PARTICULAR LEVEL.**
- 4) If none of the item in a particular category apply to the client, yet the clinician believes the youth to be at that level of impairment, circle the number corresponding to the “Exception” box at the bottom of the column and mark the bubble for the appropriate level of impairment on the profile. A reasonable explanation for the “Exception” rating should be provided.
- 5) Use the CAFAS Scoring Summary Section for completing the scoring.
- 6) For the ROLE PERFORMANCE scale, there are three subscales: SCHOOL/WORK, HOME, and COMMUNITY. After listing the score for each subscale, record the highest of these scores as the score for the Role Performance scale.
- 7) For the MOODS/SELF-HARM scale, there are two subscales: HOME and COMMUNITY. After listing the score for each subscale, record the highest of these scores as the score for the Moods/Self-Harm scale.
- 8) Sum the five scale scores for a total score for the youth. The level of overall dysfunction based on the total score may be useful in establishing priorities for treatment planning.

Frequently Asked Questions

- How is the CAFAS scored?

The CAFAS is automatically scored as the instrument is completed creating a visual profile of problem areas across settings.

- As a client undergoes treatment, the CAFAS may appear to show no improvement or it may even appear that a client is regressing over time. How will this phenomenon be addressed in performance outcome analyses?

It is understood that during the initial administration of the CAFAS a client may not yet be comfortable enough with their clinician and/or may be in a denial phase resulting in a profile indicating less impairment than may exist. After the client establishes a relationship with their clinicians and/or develop further discomfort with their situation, a second administration of the CAFAS may result in a profile that indicates significantly higher impairment than the first administration. Thus, a profile indicating higher impairment may not be directly interpreted as a negative outcome. In fact, it may actually indicate a positive outcome as the client begins to acknowledge their problems. Performance outcome analyses will need to examine and take into consideration such trends.

- If a client is admitted to services with little or no historical information, how can the clinician complete the CAFAS?

Treatment providers are encouraged to contact prior mental health therapists, case managers, and other human service agencies who have been involved with the client to examine relevant case files in an effort to reconstruct the client's level of functioning at the time of admission. The clinician should not complete the CAFAS until he/she has acquired sufficient information. The goal is for the clinician to do the best that he/she can to provide the most accurate information possible.

Sources of Further Information

Hodges, Kay. *CAFAS Self-Training Manual; CAFAS Manual for Training Coordinators; CAFAS Supplemental Vignettes Manual*; Articles on the CAFAS and Psychometric Summary.

Ordering Information:

CAFAS
2140 Old Earhart Road
Ann Arbor, MI 48105

Phone: (313) 769-9725
Fax: (313) 769-1434

ITEM	# OF ITEMS	ITEM COST	TOTAL COST
CAFAS® RATING FORMS			
CAFAS® FORM - This 12 page scale contains a "menu" of behaviorally-oriented descriptions from which the rater chooses those that best describe the client and a profile form. You will need a minimum of one form for each client:			
Package(s) of 25		\$35	
Package(s) of 100		\$120	
Package(s) of 1000		\$950	
CAFAS® PROFILE - This one page form contains a graphic representation of the various CAFAS® youth scales as well as the caregiver scales. This can be used for the second and subsequent ratings:			
Package(s) of 100		\$50	
Package(s) of 1000		\$450	
FORMS FOR SCANNING			
These are CAFAS® Profile scannable forms in which the respondents fill in bubbles with pen or pencil. The completed forms can be faxed or scanned. The form is two-sided: one side for the Youth scales and the other for the Caregiver scales.			
CAFAS® NCS SCANNABLE PROFILE FORM - Requires NCS® scanner:			
Package(s) of 500		\$225	
CAFAS® TELEFORM® SCANNABLE PROFILE FORM - Requires an IBM® compatible computer and Windows95® as well as Teleform5®:			
Package(s) of 100		\$50	
Package(s) of 500		\$225	
TELEFORM® SCANNING SOFTWARE PROGRAM - This program is installed on the computer that receives data which is scanned or faxed in. This software generates a data file. The data file can be directly imported into widely used database, spreadsheet and statistical programs. You will receive a data dictionary.		\$220	
STRUCTURED INTERVIEW			
CAFAS® INTERVIEW FORM - This multi-page structured interview asks all the questions needed in order to obtain the information necessary to rate a youth on the CAFAS®. Use of the Interview is optional:			
Package(s) of 25		\$40	
TRAINING MATERIALS			
CAFAS® Manual for Training Coordinators, Clinical Administrators and Data Managers - This manual includes guidelines for reliability training, clinical interpretation, and outcome indicators for aggregated data:			
Per Manual		\$35	
Package(s) of 10 Manuals		\$200	
CAFAS® Self-Training Manual - This manual is for training raters to be reliable. It includes instructions for scoring, demonstration vignettes, reliability vignettes and blank scoring forms. Each trainee will need to be trained. The manual is reusable.			
Per Manual		\$17	
Package(s) of 10 Manuals		\$150	
Blank Scoring Forms for the reliability vignettes (for use with the CAFAS® Self-Training Manual). If the above manual is used more than once, you will need a new form for each time it is used:			
Per Packet of Scoring Forms		\$2	
CAFAS® Supplemental Vignettes Manual - Contains 9 vignettes to be used by any person not achieving adequate reliability with the CAFAS® Self-Training Manual. Typical use: Needed for one out of 10 trainees:			
Per Manual		\$12	
SUBTOTAL			\$

ITEM	# OF ITEMS	ITEM COST	TOTAL COST
PECFAS MATERIALS			
PECFAS FORMS - This scale is a "downward" version of the CAFAS [®] for use with children ages 4 to 7 years old: Package(s) of 25		\$35	
Package(s) of 100		\$120	
PECFAS PROFILE FORM - This is similar to the CAFAS [®] Profile Form: Package(s) of 100		\$50	
PECFAS INSTRUCTIONS FOR SCORING - Used in training PECFAS raters: Package(s) of 15		\$50	
PECFAS INTERVIEW - This structured interview asks all the questions needed to obtain all of the information necessary to rate a child on the PECFAS: Package(s) of 25		\$40	
PECFAS/CAFAS [®] COMBINED PROFILE FORM - This is one-page form contains graphic representation of the youth's scores on the CAFAS [®] or the PECFAS: Package(s) of 100		\$50	
ARTICLES ON THE CAFAS			
RECOMMENDED ARTICLES ON THE CAFAS [®] Package(s) of articles		\$12	
CAFAS COMPUTER SYSTEM			
Please indicate whether you would like to receive information on the CAFAS [®] Computer Program.	Yes / No	---	---

TOTAL FROM THIS SIDE ONLY

TOTAL FROM SIDE 1

SUBTOTAL (Add above two columns)

MICHIGAN RESIDENTS: ADD 6% SALES TAX OR PROOF OF TAX-EXEMPT STATUS

SHIPPING & HANDLING IN CONTIGUOUS 48 STATES - ADD 10%

SPECIAL SHIPPING & HANDLING - OUTSIDE CONTIGUOUS 48 STATES AND 2-DAY OR OVERNIGHT DELIVERY (CALL FOR RATES)

TOTAL

\$

\$

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS™)

Name _____ Child ID # _____ Date ____/____/____
 Date of Birth ____/____/____ Age _____ Sex: ☐ boy ☐ girl Site ID # _____ Child's Zip Code _____

TIME PERIOD RATED:

- ☐ Last Month
☐ Last 3 Months
☐ Other _____

RATER:

- Name _____
☐ Case Manager (or team leader)
☐ Treating Therapist
☐ Intake Worker
☐ Non-Treating Clinician
☐ Lay Interviewer/Researcher
☐ Other _____

ASSESSMENT:

- ☐ Intake/Screening
☐ 3 mo ☐ 15 mo
☐ 6 mo ☐ 18 mo
☐ 9 mo ☐ 21 mo
☐ 12 mo ☐ 24 mo
☐ Exit from Services
☐ Change in Intensity of Service
☐ Other _____

SOURCES OF INFORMATION (check all that apply):

- In-Person Contact with:
☐ Parent
☐ Youth
☐ School Personnel
☐ Foster (or surrogate) Parent
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health Worker
☐ Public Health Worker
☐ Other _____
- Telephone Contact with:
☐ Parent
☐ Youth
☐ School Personnel
☐ Foster (or surrogate) Parent
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health Worker
☐ Public Health Worker
☐ Other _____
- Review of Documents:
☐ School
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health
☐ Public Health
☐ Other _____

ETHNIC GROUP (check all that apply):

- ☐ African-American
☐ Asian/Pacific Islander
☐ Hispanic
☐ Native American
☐ White
☐ Other _____

YOUTH'S CAREGIVER(S) (check all that apply):

- ☐ Biological Mother
☐ Biological Father
☐ Stepmother
☐ Stepfather
☐ Adoptive Mother
☐ Adoptive Father
☐ Grandparent
☐ Caregiver's Live-In Friend
☐ Other _____

YOUTH'S LIVING ARRANGEMENT and/or RESIDENTIAL PLACEMENT (check all that apply):

- ☐ Family Home (with parent or legal guardian)
☐ Private Home with Other Relatives
☐ Private Home with Non-Relatives
☐ Out of Home
☐ Regular Foster Care
☐ Therapeutic Foster Care
☐ Group Home
☐ Psychiatric Group Home
☐ Psychiatric Inpatient
☐ Residential Treatment Center
☐ Drug and/or Alcohol Program
☐ Juvenile Detention/Jail/Correctional
☐ Youth Crisis Residential
☐ Other Residential Setting
☐ Other _____
☐ Unknown

SERVICES RECEIVED SINCE LAST RATING - Other than Residential (check all that apply):

- ☐ Outpatient
☐ Evaluation, Assessment, Diagnosis
☐ Medical Monitoring
☐ Individual Therapy
☐ Group Therapy
☐ Family/Couples/Marital Therapy
☐ Alcohol/Drug Therapy
☐ Other Outpatient
☐ Intensive Community-Based Services
☐ Day Treatment/Partial Hospitalization
☐ Home-Based Services
☐ Wraparound Services
☐ Respite Services
☐ Crisis-Stabilization
☐ Other Community-Based
☐ Case Management
☐ None
☐ Unknown

PSYCHIATRIC MEDICATIONS RECEIVED (check all that apply):

- ☐ Stimulant (e.g., ritalin)
☐ Anti-depressant
☐ Anti-psychotic
☐ Other _____
☐ None
☐ Unknown

YOUTH'S LOCATION(S) (check all that apply):

- ☐ Living Within Community
☐ Living Outside Community
☐ Unknown

ENROLLED IN SCHOOL:

- ☐ Yes
☐ No

HAS JOB:

- ☐ Yes
☐ No

INSTRUCTIONS: Refer to the Self-Training Manual. Be sure to rate the youth's most SEVERE level of dysfunction for the time period specified above (e.g., the last month). The CAFAS is designed as a measure of functional status and should not be used as the sole criterion for determining any clinical decision, including need or eligibility for services, intensity of services, or dangerousness to self/others.

5 Scales	CAFAS SCORING SUMMARY Youth's Functioning	8 Scales
_____	ROLE PERFORMANCE (highest of subscale scores) SCHOOL/WORK HOME COMMUNITY	_____
_____	BEHAVIOR TOWARD OTHERS	_____
_____	MOODS/SELF-HARM (higher of subscale scores) MOODS/EMOTIONS SELF-HARMFUL BEHAVIOR	_____
_____	SUBSTANCE USE	_____
_____	THINKING	_____
_____	TOTAL FOR YOUTH based on 5 Scales	_____
_____	TOTAL FOR YOUTH based on 8 Scales	_____

CAFAS SCORING SUMMARY Primary Caregiver Resources	Other Caregiver _____
MATERIAL NEEDS _____	MATERIAL NEEDS _____
FAMILY/SOCIAL SUPPORT _____	FAMILY/SOCIAL SUPPORT _____
RISK BEHAVIORS: Items endorsed which suggest risk to youth or others <input type="checkbox"/> Self-Harm: Moods 119; Self-Harm 142-148 <input type="checkbox"/> Aggression: School 3-4; Home 43; Community 68; Behavior 89 <input type="checkbox"/> Sexual Behavior: Community 69, 77; Behavior 90 <input type="checkbox"/> Firesetting: Community 71, 78	
LEVELS OF OVERALL DYSFUNCTION BASED ON THE YOUTH'S TOTAL SCORE FOR 5 SCALES: <input type="checkbox"/> 0-10 Youth exhibits no or minimal impairment. <input type="checkbox"/> 20-30 Youth likely can be treated on an outpatient basis, provided that risk behaviors are not present. <input type="checkbox"/> 40-70 Youth may need care which is more intensive than outpatient and/or which includes multiple sources of supportive care. <input type="checkbox"/> 80 & higher Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community	

CAFAS PROFILE : YOUTH'S FUNCTIONING

ID# _____ Rater _____

Youth's Name _____ Date _____ Site _____

Level of Impairment	Role Performance: School/Work	Role Performance: Home	Role Performance: Community	Behavior Toward Others	Moods/ Self-Harm: Moods/ Emotions	Moods/ Self-Harm: Self-Harmful Behavior	Substance Use	Thinking
SEVERE 30	1	41	66	88	116	142	154	182
	2	42	67	89	117	143	155	183
	3	43	68	90	118	144	156	184
	4	44	69	91	119	145	157	185
	5	45	70	92	120		158	186
	6	46	71				159	
	7	47	72				160	
	8	48					161	
	9	49					162	
	10	50					163	
	11						164	
MODERATE 20	12	51	73	93	121	146	165	187
	13	52	74	94	122	147	166	188
	14	53	75	95	123	148	167	189
	15	54	76	96	124		168	190
	16	55	77	97	125		169	191
	17	56	78	98	126		170	192
	18		79	99	127		171	
	19		100	100				
	20		101	101				
	21		102	102				
	22	57	80	103	128	149	172	193
23	58	81	104	129	150	173	194	
24	59	82	105	130		174	195	
25	60	83	106	131		175	196	
26	61		107	132			197	
27			108	133				
28			109	134				
29			110	135				
MINIMAL/NO 0	30	62	84	111	136	151	176	198
	31	63	85	112	137	152	177	199
	32	64	86	113	138		178	
	33			114	139		179	
	34				140		180	
	35							
	36							
	37							
	38							
	39							
	40	65	87	115	141	153	181	200
COULD NOT SCORE								

For each scale: (1) mark the item number(s) which corresponds to those marked on the CAFAS form, (2) fill in the circle indicating severity level, (3) connect the circles.

	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>
ROLE PERFORMANCE School/Work Subscale <div style="border: 1px solid black; width: 50px; height: 50px; margin: 10px auto;"></div>	001 Out of job or school due to behavior (e.g., asked to leave or refuses to attend). 002 Expelled or equivalent from school. 003 Judged to be a threat to others because of aggressive potential (i.e., resulting from youth's actions or statements); monitoring or supervision needed. 004 Harmed or made serious threat to hurt a teacher/peer/co-worker/supervisor. 005 Unable to meet minimum requirements for behavior in classroom (either in regular or specialized classroom in public school or equivalent) without special accommodations. 006 Chronic truancy resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified). 007 Chronic absences, other than truancy, resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified). 008 Disruptive behavior, related to poor attention or high activity level, persists despite the youth having been placed in a special learning environment or receiving a specialized program or treatment. 009 Failing all or most classes. 010 Dropped out of school and holds no job.	012 Non-compliant behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity. 013 Inappropriate behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity. 014 Frequently truant (i.e., approximately once every two weeks or for several consecutive days). 015 Frequent absences from school (i.e., approximately once every two weeks or for several consecutive days) due to impairing behavior and/or excluding truancy or physical illness. 016 At work, missed days or tardiness results in reprimand or equivalent. 017 Behavior is disruptive, related to poor attention or high activity level, resulting in individualized program or specialized treatment being needed or implemented. 018 Receiving a reprimand, warning, or equivalent at work. 019 Grade average is lower than "C" and is not due to lack of ability or any mental or physical disabilities. 020 Failing at least half of courses and this is not due to lack of ability or any mental or physical disabilities.	022 Non-compliant behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth's activities so as to avoid predictable difficulties, more than other youth. 023 Inappropriate behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth's activities so as to avoid predictable difficulties, more than other youth. 024 Occasionally disobeys school rules, with no harm to others or to property, more than other youth. 025 Problems in school, related to poor attention or high activity level, are present but are not disruptive to the classroom (can be managed in the regular classroom, with the youth able to achieve satisfactorily). 026 School/work productivity is less than expected for abilities due to failure to execute assignments correctly, complete work, hand in work on time, etc.	028 Reasonably comfortable and competent in relevant roles. 029 Minor problems satisfactorily resolved. 030 Functions satisfactorily even with distractions. 031 School grades are average or above. 032 Schoolwork is commensurate with ability and youth is mentally retarded. 033 Schoolwork is commensurate with ability and youth is learning disabled. 034 Schoolwork is commensurate with ability and youth is a slow learner. 035 Schoolwork is commensurate with ability and youth has a learning impairment due to maternal alcohol or drug use. 036 In a mostly vocational program and doing satisfactorily. 037 Graduated from high school or received GED. 038 Dropped out of school and is working at a job or is actively looking for a job.
	011 EXCEPTION	021 EXCEPTION	027 EXCEPTION	039 EXCEPTION
Explanation:	COULD NOT SCORE: 040			

6-13

	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>
ROLE PERFORMANCE	041 Not in the home due to behavior in the home (if youth were in the home, extensive management by others would be required in order for youth to be maintained in the home).	051 Persistent failure to comply with reasonable rules and expectations within the home (e.g., bedtime, curfew); active defiance much of the time.	057 Frequently fails to comply with reasonable rules and expectations within the home.	062 Typically complies with reasonable rules and expectations within the home.
Home Subscale	042 Extensive management by others required in order to be maintained in the home.	052 Frequent use of profane, vulgar, or curse words to household members.	058 Has to be "watched" or prodded in order to get him/her to do chores or comply with requests.	063 Minor problems satisfactorily resolved.
<input type="checkbox"/>	043 Deliberate and serious threats of physical harm to household members.	053 Repeated irresponsible behavior in the home is potentially dangerous (e.g., leaves stove on).	059 Frequently "balks" or resists routines, chores, or following instructions, but will comply if caregiver insists.	
	044 Repeated acts of intimidation toward household members.	054 Run away from home overnight and likely whereabouts are known to caregivers, such as friend's home.	060 Frequently engages in behaviors which are intentionally frustrating or annoying to caregiver (e.g., taunting siblings, purposeful dawdling).	
	045 Behavior and activities are beyond caregiver's influence almost all the time (i.e., serious and repeated violations of expectations and rules, such as curfew).	055 Deliberate damage to the home.		
	046 Behavior and activities have to be constantly monitored in order to ensure safety in the home.			
	047 Supervision of youth required, which does or would interfere with caregiver's ability to work or carry out other roles.			
	048 Run away from home overnight more than once, or once for an extended time, and whereabouts unknown to caregiver.			
	049 Deliberate and severe damage to property in the home (e.g., home structure, grounds, furnishings).			
	050 EXCEPTION	056 EXCEPTION	061 EXCEPTION	064 EXCEPTION
	Explanation:			COULD NOT SCORE: 065

6-14

	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>
ROLE PERFORMANCE Community Subscale <input type="checkbox"/>	066 Confined related to behavior which seriously violated the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, rape, murder, drive-by shooting). 067 Substantial evidence of, or convicted of, serious violation of the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, rape, murder, drive-by shooting). 068 Involvement with legal system (or became a ward of the state or hospitalized) because of physically assaultive behavior or threatening with a weapon. 069 Involvement with legal system (or became a ward of the state or hospitalized) because of sexually assaultive behavior or inappropriate sexual behavior. 070 Deliberate and severe damage of property <u>outside</u> the home (e.g., school, cars, buildings). 071 Deliberate firesetting with malicious intent.	073 Serious and/or repeated delinquent behavior (e.g., stealing without confronting a victim as in shoplifting, vandalism, defacing property, taking a car for a joyride). 074 On probation or under court supervision for an offense which occurred during the last 3 months. 075 On probation or under court supervision for an offense which occurred prior to the most recent 3 month period. 076 Currently at risk of confinement because of frequent or serious violations of the law. 077 Has been sexually inappropriate such that adults have concern about the welfare of other children who may be around the youth unsupervised. 078 Repeatedly and intentionally plays with fire such that damage to property or person could result.	080 Minor legal violations (e.g., minor driving violations, unruly conduct such that complaint was made, trespassing onto neighbor's property, or harassing neighbor). 081 Single incidents (e.g., defacing property, vandalism, shoplifting). 082 Plays with fire on more than one occasion.	084 Youth does not negatively impact on the community. 085 Typically able to resolve minor problems.
	072 EXCEPTION	079 EXCEPTION	083 EXCEPTION	086 EXCEPTION
Explanation: _____				

COULD NOT SCORE: 087

6-15

	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>
BEHAVIOR TOWARD OTHERS <div style="border: 1px solid black; width: 50px; height: 40px; margin: 10px 0;"></div>	088 Behavior consistently bizarre or extremely odd. 089 Behavior so disruptive or dangerous that harm to others is likely (e.g., hurts or tries to hurt others, such as hitting, biting, throwing things at others, using or threatening to use a weapon or dangerous object). 090 Attempted or accomplished sexual assault or abuse of another person (e.g., used force, verbal threats or toward younger youth, intimidation or persuasion). 091 Deliberately and severely cruel to animals.	093 Behavior frequently/typically inappropriate and causes problems for self or others (e.g., fighting, belligerence, promiscuity). 094 Inappropriate sexual behavior in the presence of others or directed toward others. 095 Spiteful and/or vindictive (e.g., deliberately and persistently annoying to others, intentionally damaging personal belongings of others). 096 Poor judgment or impulsive behavior resulting in dangerous or risky activities that could lead to injury or getting into trouble. 097 Frequent display of anger toward others; angry outbursts. 098 Frequently mean to other people or animals. 099 Predominantly relates to others in an exploitative or manipulative manner (e.g., uses/cons others). 100 Involved in gang-like activities in which others are harassed, bullied, intimidated, etc. 101 Persistent problems/difficulties in relating to peers due to antagonizing behaviors (e.g., threatens, shoves).	103 Unusually quarrelsome, argumentative, or annoying to others. 104 Poor judgment or impulsive behavior that is age-inappropriate and causes inconvenience to others. 105 Upset (e.g., temper tantrum) if cannot have or do something immediately, if frustrated, or if criticized. 106 Easily annoyed by others and responds more strongly than other children; quick tempered. 107 Does not engage in typical peer recreational activities because of tendency to be ignored or rejected by peers. 108 Difficulties in peer interactions or in making friends due to negative behavior (e.g., teasing, ridiculing, picking on others). 109 Immature behavior leads to poor relations with same-age peers or to having friends who are predominantly younger.	111 Relates satisfactorily to others. 112 Is able to establish and sustain a normal range of age-appropriate relationships. 113 Occasional disagreements are resolved reasonably.
	092 EXCEPTION	102 EXCEPTION	110 EXCEPTION	114 EXCEPTION
Explanation:				COULD NOT SCORE: 115

6-16

	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>
MOODS/ SELF-HARM Moods/Emotions Subscale (Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic, anhedonia) <input type="checkbox"/>	116 Viewed as odd or strange because emotional responses are incongruous (unreasonable, excessive) most of the time. 117 Fears, worries, or anxieties result in poor attendance at school (i.e., absent for at least one day per week on average) or marked social withdrawal (will not leave the home to visit with friends). 118 Depression is associated with academic incapacitation (i.e., absent at least one day a week on average, or if made to attend school, does not do work) or social incapacitation (i.e., isolates self from friends). 119 Depression is accompanied by suicidal intent (i.e., really wants to die).	121 Marked changes in moods that are generally intense and abrupt. 122 Depressed mood or sadness is persistent (i.e., at least half of the time), with disturbance in functioning in at least one of the following areas: sleeping, eating, concentration, energy level, or normal activities. If <u>only</u> irritability or anhedonia (i.e., marked diminished interest or pleasure in typical activities) is present, there should be disturbance in two or more areas. 123 Youth worries excessively (i.e., out of proportion) and persistently (i.e., at least half of the time) with disturbance in functioning manifested by at least one of the following: sleep problems, tiredness, poor concentration, irritability, muscle tension, or feeling "keyed up". 124 Fears, worries, or anxieties result in the youth expressing marked distress upon being away from the home or parent figures; however, the youth is able to go to school or engage in some social activities. 125 School-age children require special accommodations because of worries or anxieties (e.g., sleeping near parents, calling home). 126 Emotional blunting (i.e., no or few signs of emotional expression; emotional expression is markedly flat).	128 Often anxious, fearful, or sad, with some related symptom present (e.g., nightmares, stomachaches). 129 Disproportionate expression of irritability, fear, or worries. 130 Very self-critical, low self-esteem, feelings of worthlessness. 131 Easily distressed if makes mistakes. 132 Sad, withdrawn, hurt, or anxious if criticized. 133 Sad (or depressed or anhedonic) or anxious in at least one setting for up to a few days at a time. 134 Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love).	136 Feels normal distress, but daily life is not disrupted. 137 Considers self to be an "OK" person. 138 Can express strong emotions appropriately. 139 Experience of sadness and anxiety are age-appropriate.
	120 EXCEPTION	127 EXCEPTION	135 EXCEPTION	140 EXCEPTION
Explanation: _____ COULD NOT SCORE: 141				

MOODS/ SELF-HARM Self-Harmful Behavior Subscale <input type="checkbox"/>	142 Non-accidental self-destructive behavior has resulted in or could result in serious self-injury or self-harm (e.g., suicide attempt with intent to die, self-starvation). 143 Seemingly non-intentional self-destructive behavior has resulted in or could likely result in serious self-injury (e.g., runs out in the path of a car, opens car door in moving vehicle), and youth is aware of the danger. 144 Has a clear plan to hurt self, or really wants to die.	146 Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, superficial razor cuts). 147 Talks or repeatedly thinks about harming self, killing self, or wanting to die.	149 Repeated non-accidental behavior suggesting self-harm, yet the behavior is very unlikely to cause any serious injury (e.g., repeatedly pinching self or scratching skin with a dull object).	151 Behavior is not indicative of tendencies toward self-harm.
	145 EXCEPTION	148 EXCEPTION	150 EXCEPTION	152 EXCEPTION
Explanation: _____ COULD NOT SCORE: 153				

6-17

	Severe Impairment <i>Severe disruption or incapacitation</i> (30)	Moderate Impairment <i>Major or persistent disruption</i> (20)	Mild Impairment <i>Significant problems or distress</i> (10)	Minimal or No Impairment <i>No disruption of functioning</i> (0)
SUBSTANCE USE (Substances = alcohol or drugs) <input type="checkbox"/>	THESE ITEMS APPLY TO YOUTH OF ALL AGES			
	154 Lifestyle centers on acquisition and use (e.g., preoccupied with thoughts or urges to use substances, cravings for substances, uses in the morning). 155 Dependent on continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms such as feeling sick, headaches, nausea, vomiting, shaking, etc.) 156 Failing or expelled from school related to effects of usage. 157 Fired or losing job related to effects of usage. 158 Frequently intoxicated or high (e.g., more than two times a week). 159 Use of substances results in serious negative consequences (e.g., injured, doing illegal acts, failing classes, experiencing physical health problems). 160 Is pregnant or is a parent and is a drug user. 161 Is pregnant or is a parent and gets drunk or routinely uses alcohol. 162 Has blackouts, drinks alone, or cannot stop drinking once started.	165 Uses in such a way as to interfere with functioning (e.g., job, school, driving) in spite of potential serious consequences (e.g., traffic violations, work or school absences or tardiness, misses out on activities, uses on school days or before work/school). 166 Gets into trouble because of usage (e.g., argues, fights with family or friends, in accident, trouble with teachers, picked up by police, breaks rules, misses curfew). 167 Behavior potentially endangers self or others because of usage (e.g., injury vulnerable to date rape). 168 Friendships change to mostly substance users. 169 High or intoxicated once a week.	172 Infrequent excess and only without serious consequences. 173 Regular usage (e.g., once a week) but without intoxication or being obviously high.	176 No use of substances. 177 Substance use is denied; unable to confirm. 178 Has only "tried" them; does not use them. 179 Occasional use with no negative consequences.
	IF YOUTH IS 12 OR YOUNGER, USE THESE ADDITIONAL ITEMS			
	163 For 12 years or younger, uses regularly (once a week or more).	170 For 12 years or younger, occasional use without intoxication and without becoming obviously high.	174 For 12 years or younger, has used substances more than once.	
	164 EXCEPTION	171 EXCEPTION	175 EXCEPTION	180 EXCEPTION
Explanation: _____				COULD NOT SCORE: 181

	Severe Impairment <i>Severe disruption or incapacitation</i> (30)	Moderate Impairment <i>Major or persistent disruption</i> (20)	Mild Impairment <i>Significant problems or distress</i> (10)	Minimal or No Impairment <i>No disruption of functioning</i> (0)
THINKING <div style="border: 1px solid black; width: 50px; height: 40px; margin: 10px 0;"></div>	<p>CANNOT ATTEND A NORMAL SCHOOL CLASSROOM, DOES NOT HAVE NORMAL FRIENDSHIPS, AND CANNOT INTERACT ADEQUATELY IN THE COMMUNITY DUE TO ANY OF THE FOLLOWING:</p> <p>182 Communications which are impossible or extremely difficult to understand due to incoherent thought or language (e.g., loosening of associations, flight of ideas).</p> <p>183 Speech or nonverbal behavior is extremely odd and is noncommunicative (e.g., echolalia, idiosyncratic language).</p> <p>184 Strange or bizarre behavior due to frequent and/or disruptive delusions or hallucinations; can't distinguish fantasy from reality.</p> <p>185 Pattern of short-term memory loss/disorientation to time or place most of the time.</p>	<p>FREQUENT DIFFICULTY IN COMMUNICATION OR BEHAVIOR, OR SPECIALIZED SETTING OR SUPERVISION NEEDED DUE TO ANY OF THE FOLLOWING:</p> <p>187 Communications do not "flow," are irrelevant, or disorganized (i.e., more than other children of the same age).</p> <p>188 Frequent distortion of thinking (obsessions, suspicions).</p> <p>189 Intermittent hallucinations that interfere with normal functioning.</p> <p>190 Frequent, marked confusion or evidence of short-term memory loss.</p> <p>191 Preoccupying cognitions or fantasies with bizarre, odd, or gross themes.</p>	<p>OCCASIONAL DIFFICULTY IN COMMUNICATIONS, IN BEHAVIOR, OR IN INTERACTIONS WITH OTHERS DUE TO ANY OF THE FOLLOWING:</p> <p>193 Eccentric or odd speech (e.g., impoverished, digressive, vague).</p> <p>194 Thought distortions (e.g., obsessions, suspicions).</p> <p>195 Expression of odd beliefs or, if older than eight years old, magical thinking.</p> <p>196 Unusual perceptual experiences not qualifying as pathological hallucinations.</p>	<p>198 Thought, as reflected by communication, is not disordered or eccentric.</p>
	186 EXCEPTION	192 EXCEPTION	197 EXCEPTION	199 EXCEPTION
Explanation: _____ <div style="text-align: right;">COULD NOT SCORE: 200</div>				

RECORD ADDITIONAL COMMENTS, CONCERNS, QUESTIONS, OR EXPLANATIONS HERE:

6-19

Caregiver Being Rated	Relationship to Child	ID #	Informant	Youth Placement	Rater	Date	Adm #
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	Severe Impairment <i>Severe disruption or incapacitation</i> (30)	Moderate Impairment <i>Major or persistent disruption</i> (20)	Mild Impairment <i>Significant problems or distress</i> (10)	Minimal or No Impairment <i>No disruption of functioning</i> (0)
CAREGIVER RESOURCES Material Needs Subscale <input type="checkbox"/>	201 Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely.	203 Frequent negative impact on youth's functioning <u>OR</u> a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	205 Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	207 Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning. 208 Able to use community resources as needed.
	202 EXCEPTION	204 EXCEPTION	206 EXCEPTION	209 EXCEPTION
Explanation:				COULD NOT SCORE: 210

	CAREGIVER RESOURCES Family/Social Support Subscale <input type="checkbox"/>	211 Sociofamilial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands.	212 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.).	213 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home.	214 Youth is subjected to sexual abuse in the home by a caregiver.	215 Youth is subjected to physical abuse or neglect in the home by a caregiver.	216 Caregiver "kicks" youth out of the home, without trying to make other living arrangements.	217 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect.	218 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized.	219 Severe or frequent domestic violence takes place in the home.	220 Caregiver is openly involved in unlawful behavior or contributes to or approves of youth being involved in potentially unlawful behavior.	221 EXCEPTION		
		222 Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources.	223 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition).	224 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.).	225 Family members are insensitive, angry and/or resentful to the youth.	226 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of youth; does not know youth's friends).	227 Failure of caregiver to provide emotional support to youth who has been traumatized or abused.	228 Domestic violence, or serious threat of domestic violence, takes place in the youth's home.	229 EXCEPTION	230 Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy.	231 Frequent family arguments and/or misunderstandings resulting in bad feelings.	232 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity.	233 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit.	234 EXCEPTION
		235 Family is sufficiently warm, secure, and sensitive to the youth's major needs.	236 Parental supervision is adequate.	237 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system.	238 EXCEPTION	Explanation:				COULD NOT SCORE: 239				

6-20

CAREGIVER BEING RATED: NON-CUSTODIAL FAMILY OR PARENT NOT LIVING IN YOUTH'S HOME

Youth's Name _____ ID# _____

Caregiver Being Rated	Relationship to Child	ID #	Informant	Youth Placement	Rater	Date	Adm #
	Severe Impairment <i>Severe disruption or incapacitation (30)</i>	Moderate Impairment <i>Major or persistent disruption (20)</i>	Mild Impairment <i>Significant problems or distress (10)</i>	Minimal or No Impairment <i>No disruption of functioning (0)</i>			
CAREGIVER RESOURCES Material Needs Subscale <input type="checkbox"/>	240 Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely. 241 EXCEPTION Explanation:	242 Frequent negative impact on youth's functioning OR a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met. 243 EXCEPTION Explanation:	244 Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met. 245 EXCEPTION Explanation:	246 Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning. 247 Able to use community resources as needed. 248 EXCEPTION Explanation:			
CAREGIVER RESOURCES Family/Social Support Subscale <input type="checkbox"/>	250 Sociofamilial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands. 251 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.). 252 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home. 253 Youth is subjected to sexual abuse in the home by a caregiver. 254 Youth is subjected to physical abuse or neglect in the home by a caregiver. 255 Caregiver "kicks" youth out of the home, without trying to make other living arrangements. 256 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect. 257 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized. 258 Severe or frequent domestic violence takes place in the home. 259 Caregiver is openly involved in unlawful behavior or contributes to or approves of youth being involved in potentially unlawful behavior. 260 EXCEPTION Explanation:	261 Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources. 262 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 263 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.). 264 Family members are insensitive, angry and/or resentful to the youth. 265 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of youth; does not know youth's friends). 266 Failure of caregiver to provide emotional support to youth who has been traumatized or abused. 267 Domestic violence, or serious threat of domestic violence, takes place in the youth's home. 268 EXCEPTION Explanation:	269 Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 270 Frequent family arguments and/or misunderstandings resulting in bad feelings. 271 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity. 272 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit. 273 EXCEPTION Explanation:	274 Family is sufficiently warm, secure, and sensitive to the youth's major needs. 275 Parental supervision is adequate. 276 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system. 277 EXCEPTION Explanation:			
				COULD NOT SCORE: 249			
				COULD NOT SCORE: 278			

6-21

Caregiver Being Rated Relationship to Child ID # Informant Youth Placement Rater Date Adm #

	Severe Impairment <i>Severe disruption or incapacitation</i> (30)	Moderate Impairment <i>Major or persistent disruption</i> (20)	Mild Impairment <i>Significant problems or distress</i> (10)	Minimal or No Impairment <i>No disruption of functioning</i> (0)
CAREGIVER RESOURCES Material Needs Subscale <input type="checkbox"/>	279 Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely.	281 Frequent negative impact on youth's functioning OR a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	283 Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	285 Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning. 286 Able to use community resources as needed.
	280 EXCEPTION	282 EXCEPTION	284 EXCEPTION	287 EXCEPTION
Explanation:				COULD NOT SCORE: 288

CAREGIVER RESOURCES Family/Social Support Subscale <input type="checkbox"/>	289 Sociocultural setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands. 290 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.). 291 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home. 292 Youth is subjected to sexual abuse in the home by a caregiver. 293 Youth is subjected to physical abuse or neglect in the home by a caregiver. 294 Caregiver "kicks" youth out of the home, without trying to make other living arrangements. 295 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect. 296 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized. 297 Severe or frequent domestic violence takes place in the home. 298 Caregiver is openly involved in unlawful behavior or contributes to or approves of youth being involved in potentially unlawful behavior.	300 Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources. 301 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 302 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.). 303 Family members are insensitive, angry and/or resentful to the youth. 304 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of youth; does not know youth's friends). 305 Failure of caregiver to provide emotional support to youth who has been traumatized or abused. 306 Domestic violence, or serious threat of domestic violence, takes place in the youth's home.	308 Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 309 Frequent family arguments and/or misunderstandings resulting in bad feelings. 310 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity. 311 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit.	313 Family is sufficiently warm, secure, and sensitive to the youth's major needs. 314 Parental supervision is adequate. 315 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system.
	299 EXCEPTION	307 EXCEPTION	312 EXCEPTION	316 EXCEPTION
Explanation:				COULD NOT SCORE: 317

Youth's Name

ID#

Rater

Date 08/18/97

Site

Level of Impairment	Role Performance: School/Work	Role Performance: Home	Role Performance: Community	Behavior Toward Others	Moods/ Self-Harm: Moods/ Emotions	Moods/ Self-Harm: Self-Harmful Behavior	Substance Use	Thinking
SEVERE 30	1	41	66	88	116	142	154	182
	2	42	67	89	117	143	155	183
	3	43	68	90	118	144	156	184
	4	44	69	91	119	145	157	185
	5	45	70	92	120		158	186
	6	46	71				159	
	7	47	72				160	
	8	48					161	
	9	49					162	
	10	50					163	
	11						164	
MODERATE 20	12	51	73	93	121	146	165	187
	13	52	74	94	122	147	166	188
	14	53	75	95	123	148	167	189
	15	54	76	96	124		168	190
	16	55	77	97	125		169	191
	17	56	78	98	126		170	192
	18		79	99	127		171	
	19			100				
	20			101				
	21			102				
	22			103				
MILD 10	23	57	80	104	128	149	172	193
	24	58	81	105	129	150	173	194
	25	59	82	106	130		174	195
	26	60	83	107	131		175	196
	27	61		108	132			197
				109	133			
				110	134			
MINIMAL/NO 0	28				135			
	29							
	30							
	31							
	32							
	33							
	34	62	84	111	136	151	176	198
	35	63	85	112	137	152	177	199
	36	64	86	113	138		178	
	37			114	139		179	
	38				140		180	
39								
COULD NOT SCORE	40	65	87	115	141	153	181	200

For each scale: (1) mark the item number(s) which corresponds to those marked on the CAFAS form, (2) fill in the circle indicating severity level, (3) connect the circles.

Youth's Name _____ ID# _____ Rater _____ Date _____ Site _____

Level of Impairment	Name: _____ Relationship: _____		Name: _____ Relationship: _____		Name: _____ Relationship: _____	
	Primary Family: Material Needs	Primary Family: Family/Social Support	Non-Custodial Family: Material Needs	Non-Custodial Family: Family/Social Support	Surrogate Caregiver: Material Needs	Surrogate Caregiver: Family/Social Support
SEVERE 30	201	211	240	250	279	289
	202	212	241	251	280	290
		213		252		291
		214		253		292
		215		254		293
		216		255		294
		217		256		295
		218		257		296
		219		258		297
		220		259		298
	221		260		299	
MODERATE 20	203	222	242	261	281	300
	204	223	243	262	282	301
		224		263		302
		225		264		303
		226		265		304
		227		266		305
		228		267		306
		229		268		307
MILD 10	205	230	244	269	283	308
	206	231	245	270	284	309
		232		271		310
		233		272		311
		234		273		312
MINIMAL/NO 0	207	235	246	274	285	313
	208	236	247	275	286	314
	209	237	248	276	287	315
		238		277		316
COULD NOT SCORE	210	239	249	278	288	317

For each scale: (1) mark the item number(s) which corresponds to those marked on the CAFAS form, (2) fill in the circle indicating severity level, (3) connect the circles.

DEMONSTRATION VIGNETTES

Barry

BACKGROUND INFORMATION

Barry is a 16-year-old male who is in the 11th grade. Last year Barry's parents divorced, with his dad moving out and taking Barry's older brother (age 17) with him. This forced Barry and his mom to move from their small rural community to an apartment in the city. Both Barry and his mother have had difficulty adjusting to the larger school system in the city, which Mrs. C describes as "awful." Barry has been going back and forth between his parents' homes, although in the past five months he has only been with his dad for a few weekends. Barry has been receiving individual counseling for about ten months for depression, but now that he has a driver's license and drives himself, he often skips the appointments.

SCHOOL

Barry shows no interest or concern about school. He usually attends school, but is often tardy. His excessive tardiness resulted in a one-week suspension from school last month. He is in the vocational training program, which Mrs. C considers "a joke," and Barry is failing every class except Auto Repair. Barry never does or hands in homework, and does not seem to be trying. Mrs. C says that this is a result of the school system and he was doing fine (Cs) in the rural district. Barry follows the rules at school and is not a discipline problem, but he refuses to do homework and fails all of his tests. Barry has a part-time job after school at an auto repair/supply store. He makes deliveries, works on the computer, and works the cash register. He hopes to be a mechanic there some day. He has no problems at work, and has been promoted twice this year.

HOME

Although Mrs. C says that Barry cares for himself without problems, she mentions that Barry sometimes neglects to brush his teeth. Barry will go through "spurts" where he will do his chores willingly, but he is "lazy" and most of the time he must be encouraged to do his work. Mrs. C says that when prodded, he does the work. Barry curses a lot, but Mrs. C finds this normal for a boy his age.

COMMUNITY

Barry was stopped for speeding and running a red light two months ago. The policeman "really scared him," so he's been more careful. He loves having a driver's license and wants to keep it.

BEHAVIOR TOWARD OTHERS

Barry has made several good friend since the move. Other than needing to be pushed to do his chores, Mrs. C reports no behavior problems at home or at school.

MOODS/EMOTIONS

Although Barry is described by his mom as usually cheerful, he has periods when he suddenly becomes extremely depressed. These began when his dad and brother left and have occurred about four times over the

last year, the latest being just over one month ago. These episodes last for several days and Barry appears depressed, sad, down in the dumps, and feeling that nothing is fun anymore. He will quit eating and "will not get off of the couch." If it is a school day, he will complain of severe headaches or stomachaches and will resist going to school. After some argument, however, he does go to school, but refuses to do any work. Then, just as suddenly, he will go back to "normal." Mrs. C feels that even in "normal" periods, Barry has a very low self-esteem.

SELF-HARMFUL BEHAVIOR

Sometimes, when he is depressed, Barry will burn some of the hair off of his arms with his cigarette.

SUBSTANCE USE

Barry has never been drunk, to Mrs. C's knowledge, but he will have a beer about once a week.

THINKING

Barry is very superstitious and will not drive his car with the windows closed, even in the winter. He also insists on having his bed next to a window and when at a friend's house for the night he will sleep next to a window.

PRIMARY CAREGIVER RESOURCES

MATERIAL NEEDS:

All material needs are satisfactorily met.

FAMILY/SOCIAL SUPPORT:

Mrs. C reports that she and Barry are very close. They will have occasional fights about his tardiness or "laziness," but for the most part they get along well. Mrs. C says that she does not know what to do when Barry is in a depressed mood, and will usually just leave him alone until he gets over the episode.

NON-CUSTODIAL CAREGIVER RESOURCES

MATERIAL NEEDS:

Mr. C has been diagnosed with severe clinical depression. On occasion, when Barry is staying with him, the apartment has been a mess and there has been no food in the house. However, since Barry has been able to drive (past five months), he is able to shop for his dad at these times.

FAMILY/SOCIAL SUPPORT:

Barry was very upset when his dad left with his brother. Mr. C is often depressed, sometimes to the point of incapacitation. Barry and his brother take care of him at these times, although Barry has pulled away from the situation considerably in the past five months. Although the boys were very close before the separation, recently there has been a lot of conflict and hostility between them.

Jamie

BACKGROUND INFORMATION

Jamie is an 11-year-old female. Her parents are divorced and she is currently living with her mother, stepfather and two sisters. Her mother and stepfather are alcohol abusers and tend to minimize their problems as well as Jamie's. Jamie has had problems with acting out behaviors for three to four years. Both she and her mother blame her behaviors on the bad influence of a neighborhood group. These behaviors include multiple episodes of stealing, alcohol use, verbal fighting and an incident six months ago in which Jamie chased a boy who had just hit her. After her last episode of shoplifting last month, it is expected that, when her case is heard in Juvenile Court, she will be placed on probation. Jamie's family life appears to be somewhat chaotic. Both Jamie and her mother told numerous stories of family members who have been hurt, murdered, or involved in drugs. Both parents are on disability for their alcohol abuse. The family lives in public housing which is in serious need of repairs. Drive-by shootings occur frequently in the neighborhood.

SCHOOL

CHILD: Jamie reports that school is going well. She stated that her only problem area is her grades, although she was unable to report them because she says her teacher will not let her see them.

PARENT: Mrs. X reports that Jamie has been having significant problems in school. She stated that Jamie does not enjoy school, does not care about her performance, and so her school work has been suffering. She reports discord with teachers and poor grades (2 Cs, 3 Ds, 1 F) due to poor effort. She doesn't do homework.

FRIENDS

CHILD: Jamie reports having several friendships without conflict within her school. She stated that the neighborhood kids had her doing bad things, so starting about two weeks ago she tried not to hang out with them anymore. She sometimes feels nervous about this, because she's afraid her old friends might hurt her for "deserting" them.

PARENT: Mrs. X describes Jamie as a loner since her trouble with the law. She has no close friends and has trouble trusting people since the neighborhood group has been threatening her.

ACTIVITIES

CHILD: Jamie reported several activities (reading, cleaning, walking, and sitting on her porch) that she is enjoying as much as before.

PARENT: Mrs. X reports that Jamie is enjoying drawing, television, and talking on the phone as much as she previously did.

FAMILY

CHILD: Jamie describes her home life as basically pleasant. She does report, however, that she wishes that her biological mother and stepfather would stop abusing alcohol and fighting with each other. For example,

she is afraid that her mother may accidentally set fire to the house when she is drunk. She explained how her mom had set a carpet on fire once when she fell asleep while smoking. She reports feeling better when she is away from home because she can do "whatever I want to do." She says that she often stays out very late and often violates rules regarding curfew.

PARENT: Mrs. X reports considerable discord between herself and Jamie because Mrs. X tries to keep Jamie from hanging around with the "wrong" kind of children. She also stated that Jamie does not like it when her stepfather drinks and her parents fight. She reports that Jamie feels better away from home. She wishes that Jamie would not stay out so late at night, and reports that they often argue about curfew violations.

FEARS

CHILD: Jamie spontaneously reported her fear of the neighborhood group members who continue to threaten her. She also discussed her fears of embarrassment and heights but they do not seem to interfere with functioning.

PARENT: Mrs. X reported Jamie's fear of snakes, dogs, and embarrassing herself. None met the criteria for phobia.

WORRIES AND ANXIETIES

CHILD: Jamie reported several worries. Her worries about death or harm to family members and her worries about the neighborhood group do not impair functioning.

PARENT: Mrs. X spontaneously reported Jamie's worry that her mother drinks too much. Mrs. X endorsed several other worries including concern about family members' physical and mental health. She was able to give past family experiences that would explain each of Jamie's concerns. None of these concerns were preoccupying or incapacitating.

SELF-IMAGE

CHILD: Jamie describes herself as a nice 5th grader who dresses nice, but she views herself as slow in school and too self-conscious. She could not report something that she was proud of about herself.

PARENT: Mrs. X reports that Jamie views herself in very negative ways, such as dumb and self-conscious. She states that Jamie sees nothing to be proud of herself about and seems to have low self-esteem.

MOOD (SADNESS) AND BEHAVIOR

CHILD: Jamie says that her mood is basically good although she does report having clinging feelings toward her mother. She explained that she has been sad lately because although she knows her old friends were "bad news," she feels lonely and hurt.

PARENT: Mrs. X reports that Jamie is basically a cheerful person. She becomes sad and withdrawn when she is punished and can't go outside. She reports that Jamie wishes she could have more friends that don't get into trouble and that her parents would stop drinking.

PHYSICAL COMPLAINTS

CHILD: Jamie reports having stomachaches, particularly when she gets scared or nervous, that do not interfere with activities. She also reports a high activity level.

PARENT: Mrs. X confirmed Jamie's report.

ACTING OUT

CHILD: Jamie stated that what makes her feel mad or angry is when, "Mom goes out and does not come back for a long time." She reports several acting out behaviors including arguing, cursing, verbal fighting, stealing, and using alcohol with her neighborhood group. She did get into trouble at school two weeks ago for trying to pick a fight. She and her friends have a reputation for bullying and intimidating other kids. She reports that she drinks with her friends while at school several times a week, and that she was getting drunk every weekend.

PARENT: Mrs. X reports that Jamie gets angry when she doesn't get attention and will usually cry. She states that Jamie has several problems with her ability to pay attention and is considered a troublemaker at school. As for her other acting out behaviors, Mrs. X blames Jamie's friends. These behaviors include shoplifting, alcohol abuse, lying, curfew violations, and trouble following school rules.

REALITY TESTING

CHILD: Jamie reports experiencing odd things, including the feeling of blood running down her leg. Jamie realized that these things were not real at the time. Her friends laugh at her when she has these feelings because her behavior will abruptly change and she is unable to continue whatever activity she was involved in at the time.

PARENT: Mrs. X confirmed Jamie's report.

BACKGROUND INFORMATION

Denny is a 12-year-old male who is in the 6th grade. He lives with his biological parents and an older brother. Because of serious financial problems, the family is currently living with Denny's paternal grandmother, her new husband, and his two sons. Denny has been placed in an emotionally impaired classroom since kindergarten. At the age of 9 years, he had to be hospitalized for a period of ten weeks as a result of his uncontrollable behavior. Over the next two years, Denny received outpatient care, medication (for attention deficit disorder), and several unsuccessful attempts at mainstreaming. This school year began with Denny once again placed in an emotionally impaired classroom. Mrs. X has refused to accept medication for him any longer because she feels that his growth has been stunted by his continued use of the drugs. This year, his behavior has become so harmful and destructive that three weeks ago he was expelled from school entirely.

SCHOOL

This year, Denny's grades have dropped to all Ds. Mrs. X says that Denny "hates school" and is truant at least once a week. Since discontinuing his medication (two months ago) Denny has found it very difficult to concentrate and to motivate himself to do any work. He has frequently been suspended from school for aggressive and noncompliant behavior in the classroom. He has major attention problems and hyperactivity which have become so serious over the past two months that he is not able to continue even in the special setting provided by his school.

HOME

Denny is very troubled by his current living arrangements. He resents having to share a room with his brother and his new stepuncles. He will do chores only if given repeated warnings. He is constantly fighting with other family members and has threatened them with kitchen knives. Last month he hit his brother with a glass bottle. His brother needed fifteen stitches to repair the gash. Denny consistently provokes others by deliberately doing things that annoy them. He and his father are often yelling and swearing at each other. Denny uses obscene language and curse words as a normal part of his vocabulary. Mrs. X says that she is in tears a couple of times a week because Denny's problems seem more than she can manage.

COMMUNITY

Denny often lies and steals. He has been so disruptive at movie theaters that they will not let him in anymore. He has bragged about acts of vandalism such as puncturing neighbors' tires, breaking windows, and painting obscene words on the walls of public restrooms. Although Denny has had no contact with the police, Mrs. X says that it is "just a matter of time" before he does.

BEHAVIOR TOWARD OTHERS

Denny's verbally and physically aggressive behavior makes it very difficult for him to sustain any positive peer relationships. He has bitten, hit, and kicked teachers and classmates. Last year he kicked a pregnant teacher in the stomach. He is very argumentative and defiant. He will initiate physical fights with classmates

and has threatened them with whatever object is in his immediate reach. He admits that he is cruel to people and animals. Last week, when playing with his pet lizards, he became overly aggressive and choked one of them to death. Denny says that he has friends, but that they annoy him sometimes and that they cannot be trusted. Mrs. X says that Denny really does not have any friends because of his behavior.

MOODS/EMOTIONS

Mrs. X reports that Denny has erratic and frequent mood changes. She states that his moods of sadness and irritability have become frequent and of greater intensity over the last several months. He worries about fires, especially at night, and is excessively worried about his parents' health. He feels sad, hopeless, and that there is no reason to live. Denny feels very guilty about his behavior, but foresees no immediate change in his future. Denny reports continual stomachaches and extreme difficulty falling asleep. He says that it takes him up to four hours to calm down after going to bed so that he can get to sleep. He says that his mind just "keeps racing" and will not slow down.

SELF-HARMFUL BEHAVIOR

Denny has seriously considered suicide. Last week he wrote a suicide note, but "chickened out." He says that next time he won't take the time to write a note, but will just put the plastic bag he keeps in his drawer over his head and suffocate himself. He said, "I am not going to be here much longer." Mrs. X reports that occasionally Denny will get so frustrated with himself that he harms himself. Last month at school he became so angry that he dug a pencil up his arm until it bled.

SUBSTANCE USE

Denny denies any substance use.

THINKING

No impairing thought disturbances were reported.

PRIMARY CAREGIVER RESOURCES

MATERIAL NEEDS:

Mrs. X says that the last few months have been very hard on the family. They went through some very "rough" times when they had to file for bankruptcy. She says that Denny's problems were made worse when they finally had to move in with his grandmother. Although he has to sleep on the floor, at least this month he "has a roof over his head."

FAMILY/SOCIAL SUPPORT:

Mrs. X feels that Denny is a major cause of conflict in the family. Arguments between her and her husband have become more frequent and the tension more noticeable. She says that her husband has a bad temper and often becomes verbally insulting and blames Denny for the family's problems. Both parents agree that it might be a lot better were Denny to live elsewhere.

Wanda

BACKGROUND INFORMATION

Wanda is a 7-year-old female in the first grade. She lives in an apartment with her mother and 10-year-old brother. Her parents have recently separated (2 months ago), but her father lives nearby and regularly visits. When he does, he is usually drunk and abusive to family members. Wanda and her brother began seeing a counselor six weeks ago, after her mother began attending AA meetings.

SCHOOL

Wanda is doing well at school, although she sometimes gets distracted. She loses papers almost every other week. This has not become a serious problem, according to Mrs. F.

HOME

At home, Wanda refuses to do her chores when she is supposed to do them. Getting her to carry her dishes to the sink has become a daily fight between Wanda and Mrs. F. She also does not come directly home from school, but will always have some excuse as to why she was late. She has threatened others in the family, has broken toys, windows, and lamps in the home, and will scream at her mother and brother. She often leaves the house in the evenings to play with her friends, but will not come back in at her curfew (when it gets dark). Mrs. F has to send her son out to look for Wanda almost every night. Mrs. F feels that she has little control over Wanda.

COMMUNITY

Wanda has tried to shoplift candy many times from the corner store. She is usually caught, but she keeps trying new ways to sneak into the store.

BEHAVIOR TOWARD OTHERS

Mrs. F says that Wanda's behavior at home is very aggressive and disruptive. She tore her mother's shirt last month during one of her tantrums. At home, Wanda is very argumentative and quarrelsome and frequently has angry outbursts. Away from home, she is "the teacher's pet." Mrs. F feels that Wanda has very poor judgment and has no fear of punishment. She has a group of friends, several of whom are "little bitches," according to Mrs. F. Wanda and her friends are always conning other children, especially younger kids. They will tease some of the other children to the point of tears, but "that's what happens to real popular kids like Wanda."

MOODS/EMOTIONS

Mrs. F describes Wanda as being "whiny and complainy." She has sudden mood changes, going from fine one minute, to screaming the next. She is very emotional a lot of the time, either crying or screaming. Wanda has been very worried lately and seems to be getting worse. She worries "way out of proportion." At home, she is always either depressed or sad. She is irritable much of the time, and lately she has complained of stomachaches a lot.

SELF-HARMFUL BEHAVIOR

Although Wanda has never actually attempted suicide, she often threatens to do so. Two weeks ago, she grabbed a kitchen knife and threatened to kill herself. "She got a good spanking for that one," says Mrs. F. According to her mother, Wanda would never really do anything to harm herself.

SUBSTANCE USE

Both parents are alcoholics, with Mrs. F having been attending AA for the last two months. She says that before that time, they would let their kids drink occasionally "to get them used to the stuff so that they would know how to use it properly." She says that Wanda hasn't been allowed to sip anything since she (Mrs. F) started at AA. However, she is pretty sure that once in a while, Wanda sneaks a sip from a glass left by her father on one of his visits. Mrs. F has never noticed any negative results from the alcohol use.

THINKING

Mrs. F reports that Wanda will see bears in her room almost every night. She refuses to go to sleep until her brother comes in her room to "catch the bears." Mrs. F says that they have gone through a routine for a couple of years whereby her son will enter the room and go through a big game of catching the bears and leading them outside. Wanda insists that they are there and once (when her brother was spending the night at a friend's house) became so hysterical that he had to be called home just to "catch the bears." Mrs. F says that this game is silly, but that it is easier to play it than to put up with Wanda's tantrums and that "she will outgrow this pretty soon."

PRIMARY CAREGIVER RESOURCES

MATERIAL NEEDS:

Due to her parents' alcoholism, there have been times when there was not enough food in the house. Two months ago, Wanda became quite ill with the flu and Mr. and Mrs. F were too drunk to care for her. Their son called their grandmother to come and help. Wanda was very sick and had to be hospitalized overnight for dehydration. This scared Mrs. F so much that she began seriously attending AA meetings. She also "kicked my bum of a husband out of the house." Mrs. F says that she is straightening out her life, has a job now, and that things are better.

FAMILY/SOCIAL SUPPORT:

Mrs. F says that there are a lot of problems in the family, but that they are beginning to work on them. Right now, she feels that family members cannot talk to each other without screaming and that they do not feel close. Mr. F will regularly come by drunk and screams at Wanda and physically fights with Mrs. F and her son. The police have been called a couple of times by neighbors, but no charges have been filed. Mrs. F feels that Wanda's problems are related to the turmoil that has gone on in the last couple of months. She says that Wanda and her brother attend counseling and that she attends AA and a parenting class.